Annual Performance Report
2009

MSOP
Minnesota Sex Offender Program

January 2010
Minnesota Sex Offender Program
444 Lafayette Road North
Saint Paul, MN 55155-0992

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Executive Summary

Executive Summary M.S. 246B.035 requires the electronic submission of an annual performance report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over funding for the Minnesota Sex Offender Program (MSOP) by January 15th of each year. The statute stipulates the report must include information on the following:

1. description of the program, including strategic mission, goals, objectives and outcomes;
2. program wide per diem;
3. annual statistics; and
4. the sex offender program evaluation report required under section 246B.03.

On July 1, 2009, MSOP opened 400 additional beds in Complex 1 in Moose Lake. When this addition was opened, 200 clients were transferred from the facility MSOP was renting from the Department of Corrections (DOC) (Annex). This new building allows for enhanced security, streamlined operational activities, and increased fiscal efficiency. This allowed the Annex to be returned to the DOC. Re-construction was completed, and the Annex was returned to DOC on July 15, 2009, which allowed DOC to return inmates from the rented private facility, in Appleton, Minnesota.

Another accomplishment involved enhancing Community Preparation Services (CPS). This was done by obtaining approval from licensing entities to allow MSOP to utilize the Halvorson House for use by MSOP CPS. In April 2009, MSOP opened its own Community Preparation Services (CPS) program in the Halvorson House, a single family home on the St. Peter campus, outside of the secure perimeter. Two clients moved in initially – one from MSOP's Supervised Integration (MSI) program and one from the CPS program operated by State Operated Forensic Services (SOFS). Two more clients from MSI moved into the Halvorson House in June and October. As of January 1, 2010, there were 4 clients in the 5-bed Halvorson House.

Despite the challenges of the physical design, MSOP made a diligent effort to design physical design space conducive to programming and treatment needs of clients. Although MSOP is one program, it operates across two campuses. During the last year, the mission and clinical focus of each campus was clarified and strengthened. The Admissions and Assisted Living Units were moved from St. Peter to Moose Lake. All admissions assessments and primary treatment occur in Moose Lake. After clients make significant meaningful changes in the first two phases of treatment, they are considered for transfer to the St. Peter campus. The primary mission of St. Peter centers on reintegration. The campus houses the MSI unit and CPS. In these units clients are given increased therapeutic privileges to demonstrate their abilities to use new coping skills and risk management techniques in settings with less structure. St. Peter also provides the Alternative Program for clients with impaired cognitive abilities due to developmental disabilities, head injury or trauma, and other neuropsychological insults.

Section I

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

Description of the Program: The Minnesota Sex Offender Program (MSOP) provides comprehensive sex-offender-specific treatment to individuals ("clients") who have been civilly committed by the courts. MSOP operates treatment facilities in Moose Lake and Saint Peter. Clients are committed as Sexual Psychopathic Personalities ("SPP") or as Sexually Dangerous Persons ("SDP") or as both SPP and SDP, only after a court has concluded that the individual meets the legal criteria for commitment. Such commitments are for an indeterminate time and, in most cases, follow an individual's completion of a period of incarceration.[1]

With the exception of clients in the MSOP Alternative Program, clients begin treatment at the Moose Lake facility.[2] After successfully progressing through the majority of their treatment, clients are transferred to the St. Peter facility to complete treatment and begin working toward reintegration. All clients participating in treatment develop skills through active participation in group therapy. Clients are provided opportunities to demonstrate meaningful change through their participation in rehabilitative services such as education classes, therapeutic recreational activities, and vocational work program assignments. MSOP staff observe and monitor clients in treatment groups as well as in all aspects of daily living to determine and provide feedback on how clients are applying new knowledge and prosocial skills.

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

Strategic goals & objectives: Over the last 18 months, MSOP executive leadership has established goals geared toward clarifying the treatment model, fostering cohesiveness and consistency in staff, and identifying areas in which efficiencies could be increased. The following areas of focus and development were selected and in 2010 will be operationalized and utilized to establish and measure outcomes in MSOP strategic planning. MSOP is committed to creating a safe and respectful environment for clients and staff. Respect is defined as transparent and proactive communication, accountability, and recognition of the individualized needs of clients. Inherent in respect is the belief that all people are capable of making meaningful change if they possess the motivation and tools to do so.

Staff development

Goal: Develop and maintain a confident, healthy, and professional team.

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

[2] Clients with low cognitive skills are placed in the MSOP Alternative Program and complete all phases of their treatment at St. Peter.

Therapeutic environment

Goal: Establish MSOP as a world class, research-based, treatment program that is client-focused and has a clear progression across the continuum of care.

Values

Goal: Create a values-based environment. These core values underlie the treatment program include a change-is-possible orientation, credibility, research-based, effectiveness, authenticity and integrity, transparency, and efficiency.

Learning organization

Goal: Establish a dynamic culture of learning at all levels of our world-class organization, which recognizes the many faces of learning.

Responsibility to the public

Goal: Partner with community stakeholders to enhance, develop, and effectively manage a world-class sex offender treatment program.

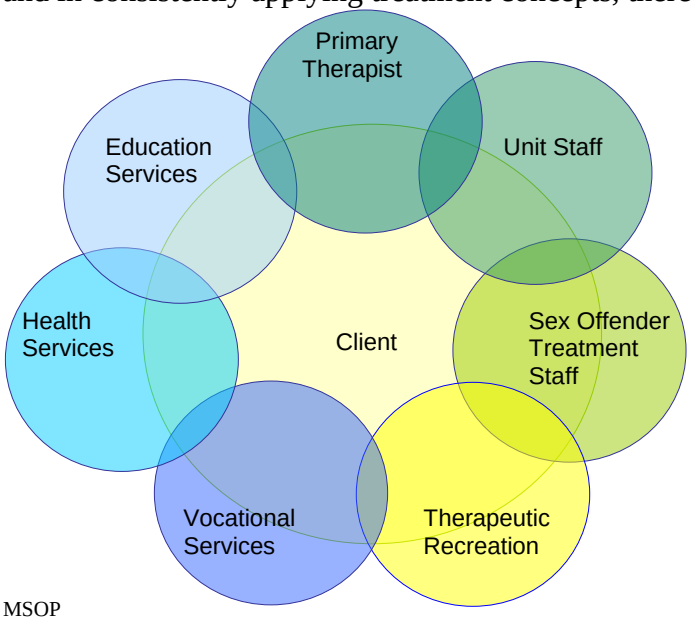
Section II
Treatment Model and Progression

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

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

Clients progress through three phases of treatment. In the initial treatment phase, clients address treatment-interfering behaviors and attitudes. Following this preparation, clients in the intermediate treatment phase focus on their patterns of abuse and on identifying and resolving the underlying issues in their offenses. Clients in the final treatment phase focus on maintaining the changes they have made and demonstrating their ability to consistently implement those changes and manage their risk.

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



All clients follow Individualized Treatment Plans. The plan is developed with the client's multi-disciplinary team and is based on the results of a sexual offender assessment. The plan's goals are written to address the client's individual risk factors for recidivism and specific treatment need areas. Treatment progress is reviewed on a quarterly basis, and plans are modified as needed.

Treatment Design
MSOP clients who choose to engage in treatment participate in a sexual offender assessment that sets the foundation for their individualized treatment plan. Clients are then placed in programming based on their clinical profile. MSOP provides sex-offender-specific treatment to meet the needs of all clients. On average, clients participate in six to ten hours weekly of sex-offender-specific treatment with additional programming hours as warranted by individual need. See Appendix 2 for examples of client programming schedules.

MSOP is one program at two facilities, one in Moose Lake and another in St. Peter. Each facility contributes to the mission of MSOP by specializing in different components of the treatment process.

The Moose Lake facility houses individuals who have been petitioned for civil commitment but not yet committed, clients who refuse to participate in sex-offender-specific treatment, and clients participating in initial and primary stages of treatment. Individuals who have successfully demonstrated meaningful change and have progressed through treatment are transferred to St. Peter to begin the reintegration process.

In addition to the components of reintegration, St. Peter is also the location of the Alternative Program for clients with compromised executive functioning and who therefore are not suited for conventional programming. These clients are in need of unique treatment approaches due to developmental disabilities, traumatic brain injuries, or severe learning disabilities.

MSOP Treatment Units:
Admissions (ADM) Clients newly admitted to MSOP and/or are involved in the commitment proceedings but who have not been finally committed.

Alternative Program (MAP) Clients with compromised executive functioning. Alternative clients may have cognitive impairments, traumatic brain injuries and/or profound learning disabilities. It is unlikely that these clients would be successful in a conventional cognitive behavioral treatment program and are in need of specialized programming.

Assisted Living Unit (ALU) Clients who are medically compromised to the extent of requiring specialized care.

Behavior Therapy Unit (BTU) Clients who demonstrate behaviors that are disruptive to the general population and/or affect the safety of the facility: criminal behavior, repetitive restrictions to maintain safety, threatening behavior (i.e., assaults on staff/peers, thefts, predatory type behaviors, etc.) are treated on this unit with the goal of mainstreaming back into treatment once the treatment-interfering behaviors have been resolved.

Conventional Programming Unit (CPU) Clients motivated to participate in sex-offender-specific treatment and are meeting behavioral expectations.

Corrective Thinking Unit (CTU) Clients who present with unique treatment needs including generally high levels of psychopathy and antisociality. Their traits often include: grandiosity,

instrumental emotions, impulsivity, callousness, irresponsibility, conning and deception, belligerence, and lack of sustained effort in treatment.

Skill Building Unit (SBU) Clients with significant mental health diagnoses including Axis I diagnoses that do not meet the requirements for a transfer to the Minnesota Security Hospital and/or significant personality disorders that result in persistent emotional instability and/or potential self harm.

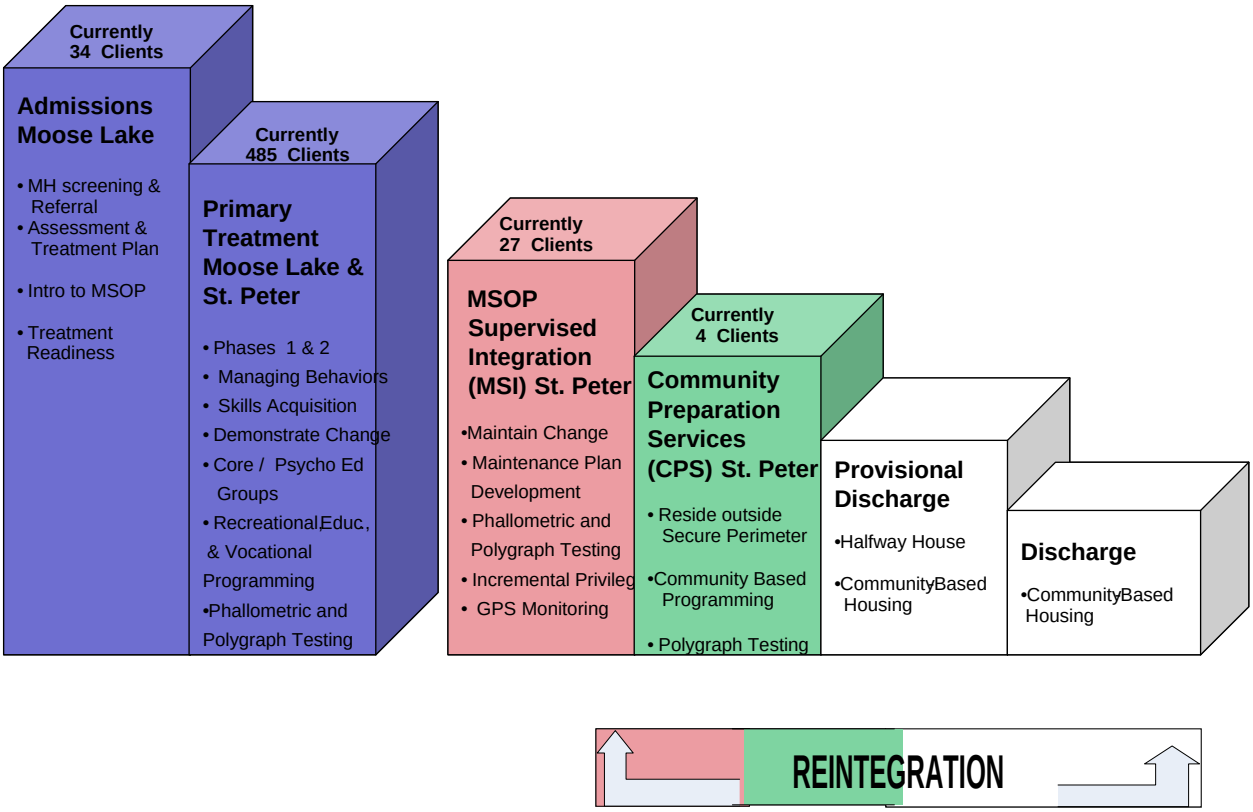
Therapeutic Concepts Unit (TCU) Clients refusing to actively participate in sex-offender-specific treatment programming.

Young Adult Unit (YTU) Clients who are between the ages of 18 and 25 and do not meet criteria for the Alternative Program or CTU programming. Most of these men have not been incarcerated as an adult.

Treatment Progression

Clients progress through treatment by completing group module requirements, treatment assignments, risk management assessments, and by demonstrating they have changed their thinking and behaviors. Progress in treatment is assessed quarterly. Placement in treatment is determined by program matrix factors (See Appendix 1). These factors are reflective of the criminogenic needs of all sexual offenders. These treatment focused-areas are supported in the current professional literature and are indicators of risk for recidivism. At quarterly and annual reviews, clients conduct a self-assessment, and the results are compared to the assessment of their multi-disciplinary team. Individual treatment plans are modified accordingly.

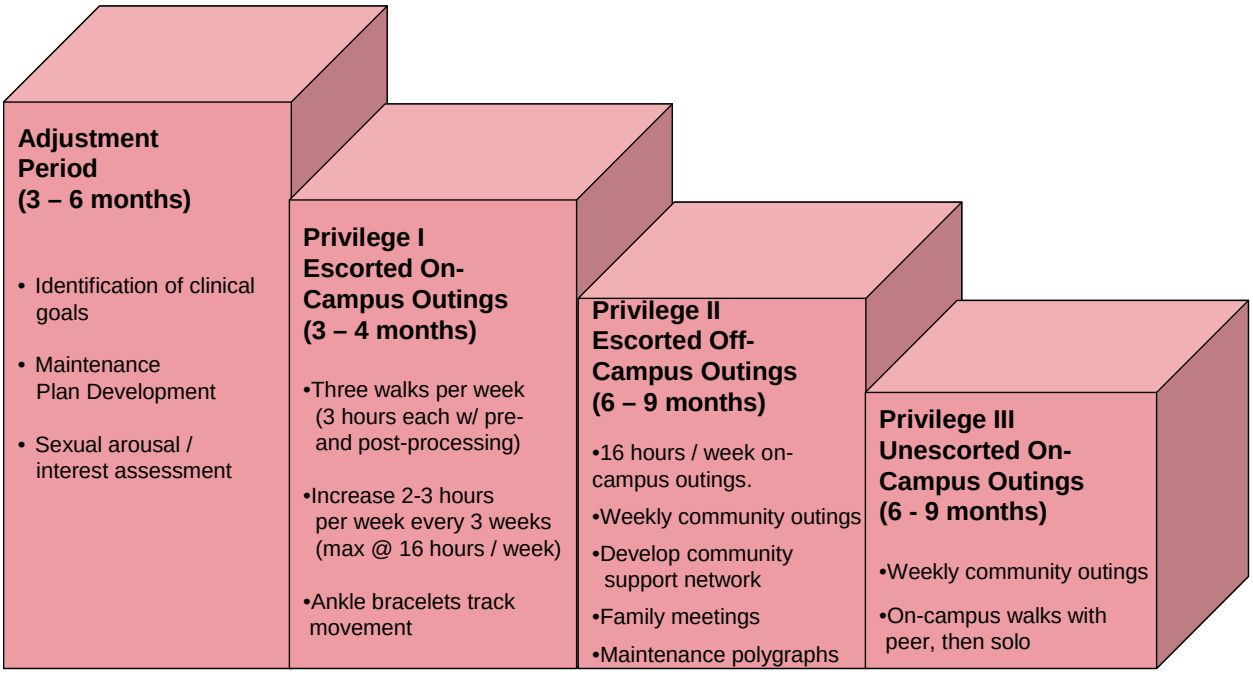
Once clients have completed the majority of primary programming and have demonstrated meaningful change and successful risk management, they are assessed for--and transferred to St. Peter to begin--reintegration programming. This process consists of two program components: MSOP Supervised Integration ("MSI") and Community Preparation Services ("CPS").



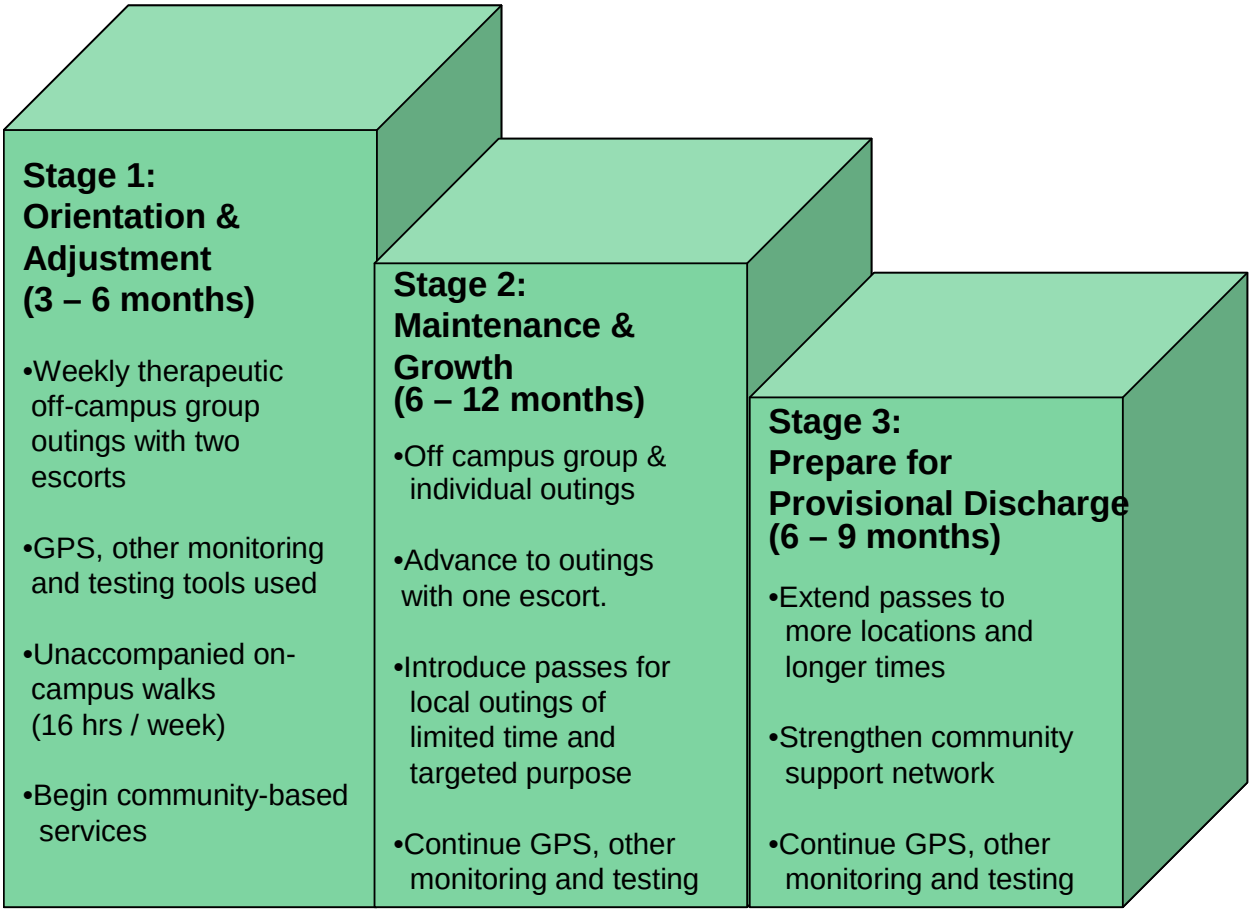
Reintegration

Reintegration is a transitional period designed to provide opportunities for clients to apply their acquired skills and to master increasing levels of privileges and responsibility while maintaining public safety. The focus of treatment during reintegration includes "decompression" from many years (often 15-20) of institutionalization. Clients are provided opportunities at a gradual pace to apply internalized treatment skills and behavioral changes.

MSOP Supervised Integration (MSI) Placement in this unit represents the beginning of the transitional phase of treatment at MSOP and focuses on solidifying skills for living safely in the community. Clients are able to participate in privilege progression with accompanied on-campus, accompanied off-campus, and unaccompanied on-campus liberties. MSI clients have Area Monitoring System (AMS) electronic monitoring bracelets. The number of clients in MSI increased from 27 to 31 in 2009.



Community Preparation Services (CPS) After MSI clients have demonstrated consistent application of newly acquired skills and management of community environmental triggers, a client is generally considered ready for transfer to CPS, which can only occur via the judicial appeal panel process. CPS clients have both AMS and GPS monitoring. Initially, a CPS client is employed on campus and is allowed both campus and escorted community outings.



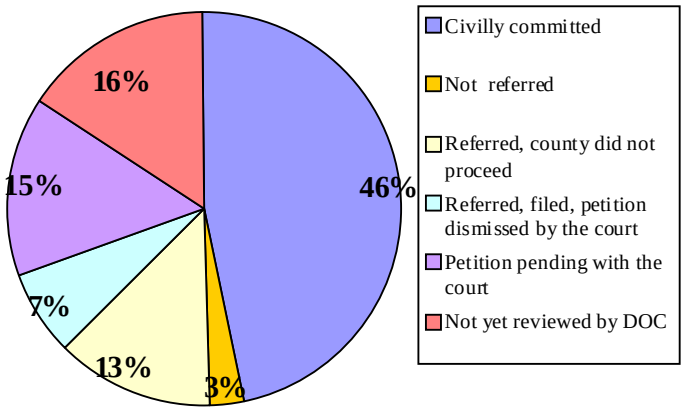
Section III
MSOP Department of Corrections Site

MSOP operates a collaborative, 50-bed, sex offender treatment program located at the Minnesota Correctional Facility in Moose Lake. This program provides sex offender treatment similar in scope and treatment design to the primary phase at the MSOP Moose Lake facility. Program participants are still serving their correctional sentences and have histories that indicate they are likely to be referred for civil commitment. Three outcomes may occur as the result of a client participating in this treatment prior to the end of their sentence in DOC:

1) The client is viewed as having made such significant progress toward management of risk factors that the county does not petition for their civil commitment.
2) The county still pursues civil commitment, but the court determines that the client has made sufficient progress so that civil commitment may not be necessary. For example, the judge may order treatment in a community-based setting.
3) The county pursues commitment, and the client is civilly committed to MSOP but is able to start at a later phase in treatment and/or move through MSOP more quickly based upon the clinical work the client has already completed in the MSOP DOC site with MSOP treatment staff.

There have been 236 men that have been admitted to the MSOP-DOC program since 2001. Of the 236, there are currently 50 still in the program and 5 who are deceased. Of the 181 men who have been discharged from the program:

Disposition of MSOP DOC clients



- 47% (85) are currently civilly committed (reside in MSOP or DOC),
- 3% (6) were not referred to the county for consideration for civil commitment,
- 13% (23) were referred to the county, but the county did not pursue civil commitment,
- 7% (12) referred and civil commitment was pursued, but the court dismissed the petition,
- 15% (27) have been referred and have petitions for civil commitment pending with their counties,
- 15% (28) have not yet been reviewed for referral (reside in DOC).

Current data suggests MSOP clients who participated in the DOC program prior to commitment are progressing through treatment in MSOP at a slightly faster rate than their counterparts who did not participate in MSOP-DOC programming prior to commitment.

There is additional data suggesting clients coming into MSOP from MSOP-DOC are joining treatment and staying in treatment at higher rates than their counterparts. This data is preliminary, but promising. MSOP is in the process of implementing consistent benchmarks and statistical analysis to track this information.

Section IV
Program-Wide Per Diem and Fiscal Summary

Since 2007, the Minnesota Sex Offender Program (MSOP) has made a number of improvements in structure, operations, budget and clinical practice. MSOP's fiscal management continues to focus on:

- Increasing public safety through enhanced security;
- Addressing growing costs;
- Managing and planning for the continued client population growth; and,
- Establishing leadership and infrastructure, including fiscal management.

The per diem for MSOP has decreased $59.00 (fifteen percent) from $387 for FY2007 to $328 for FY2010. Although client population increased during this time, MSOP was able to reduce costs by aggressive cost control measures in both salary and non-salary budgets. These measures included reducing the staff compliment by approximately twenty percent. Additionally, MSOP thoroughly analyzed the utilization of non-salary funds. Costs in salary and non-salary areas were reduced while maintaining and improving client treatment and care, as well as public safety.

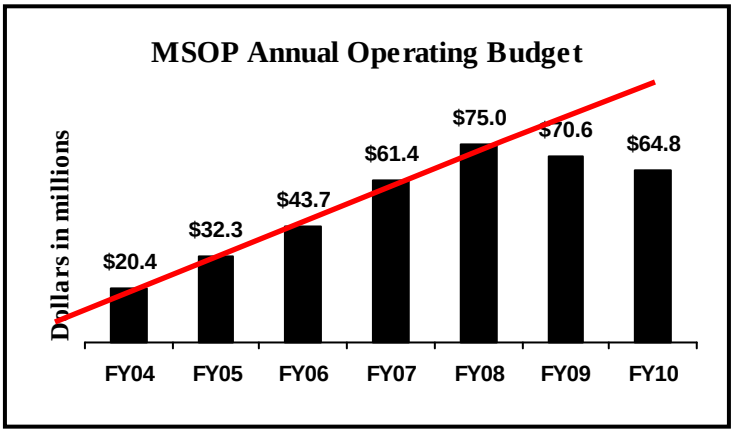
MSOP Changes FY08 to FY10	
Budget change	-13.6 %
Per Diem change	-10.9 %
Client change	+20.7 %
Staffing change	-23.2%
Budget change	-$10.2 Million
FY10 budget	$64.8 Million

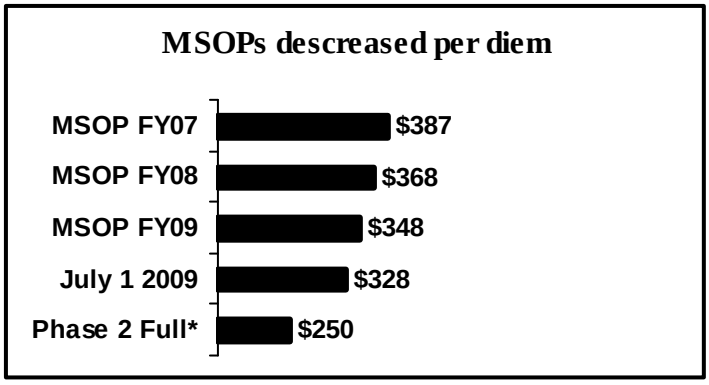
Strengthening Fiscal Management

MSOP's management has increased fiscal accountability through the development of new budget structures, processes and controls. Budget managers have been assigned, trained and are held accountable for managing all MSOP budgets.

Implemented Cost Reductions

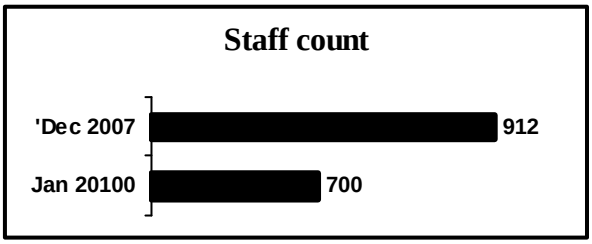
Through aggressive cost control measures, MSOP has been able to reduce costs by 13.6% since FY08, a savings of more than $10 million annually. Without the cost reduction strategies and cost savings associated with moving into the Complex 1, the MSOP budget trend would have reached over $100 million today.





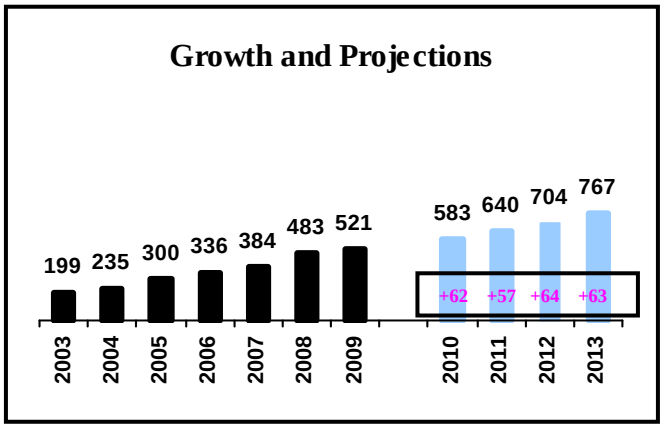
As a result of the decreasing costs and increasing client population, MSOP's per diem has been reduced by 10.9% (from $368 in FY08 to $328 in FY10).

To achieve these reductions, MSOP extensively reviewed and restructured staff roles, responsibilities and staffing patterns. MSOP has reduced staff by approximately 23.3% since 2007.



Managed Client Growth

Since 2003, MSOP admission rates have drastically increased. In the past two years, MSOP has experienced a 20.7 percent growth in the client population. Factoring in current trends, laws and policies, the November 2009 client projection shows an average continued increase of 66 clients per year.



Maximized Physical Space

MSOP opened the 400-bed Complex 1 building in July 2009. Prior to its construction, MSOP had been renting space from the Minnesota Correctional Facility in Moose Lake. Use of this facility was costly, due to numerous staffing, security and programming challenges, which increased MSOP's operating budget and per diem.

MSOP Per Diem

Although there are 21 other civil commitment programs (20 state programs and one federal program) in the country, there is no standard method for calculating per diem. However, a survey conducted by MSOP Fiscal Services learned that most states do not include the entire cost of a program. MSOP uses a comprehensive per diem calculation that includes all direct and indirect costs. The estimated additional costs for a new admission into MSOP is $150 per day (marginal per diem). As the MSOP population increases, this marginal per diem is averaged against the overall per diem, resulting in the overall per diems going down (i.e. estimating in today's dollars that the overall MSOP per diem will be $250 per day when Phase II is built and at full capacity).

Fiscal Year 2010 Projected Per Diem

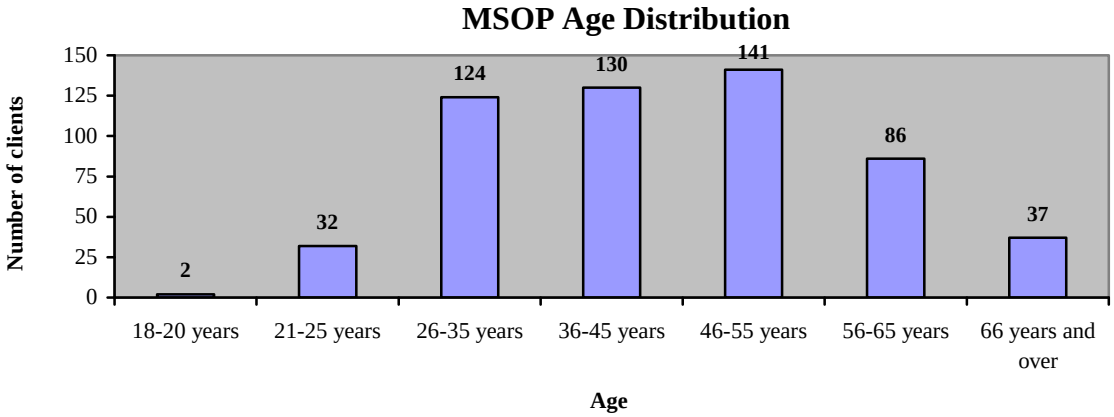
Direct Costs	**Annual**	**Per Diem**
Clinical	$ 8,355,800	$ 39.13
Health Care & Medical Services	5,718,700	26.78
Security	29,963,078	140.33
CPS & Community Preparation	1,036,789	4.86
Dietary	2,314,550	10.84
Physical Plant & Warehouse	6,045,918	28.31
Support Services	9,347,665	43.78
Vocational Program	2,060,500	9.65
Total Direct Costs	$ 64,843,000	**$ 303.68**
Additional Allocations		
Statewide Indirect[1]		$ -
DHS Indirect[2]		1.85
Building Depreciation		8.79
Bond Interest		13.03
Capital Asset Depreciation		0.69
Total Additional Allocations		$ 24.36
Total		$ **328.04**

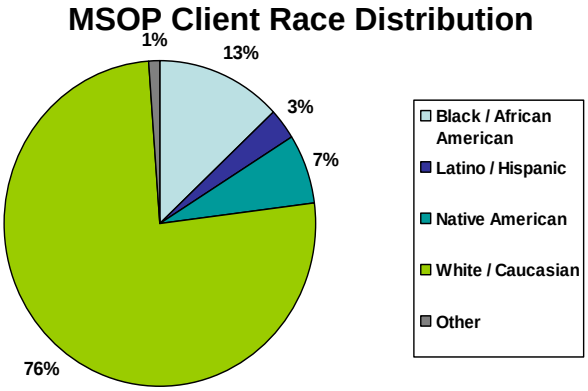
[1] Minnesota Management & Budget charges for services such as central purchasing, payment processing, electronic fund transfers, and other services provided to all state agencies.

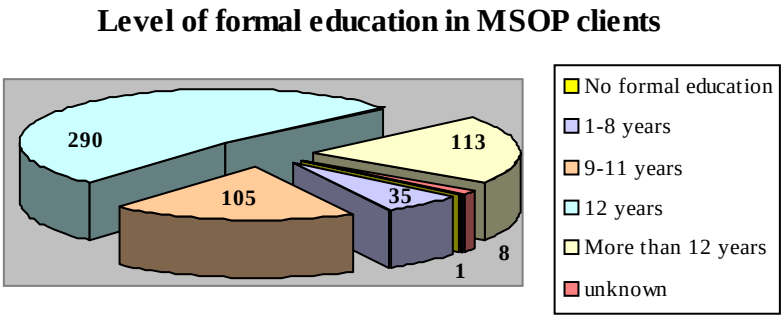
[2] Allocated cost of agency central functions such as, but not limited to: financial operations, budgeting, telecommunications and media services, occupancy, compliance and internal audit, legislative coordination, and licensing.

Section V
Annual Statistics

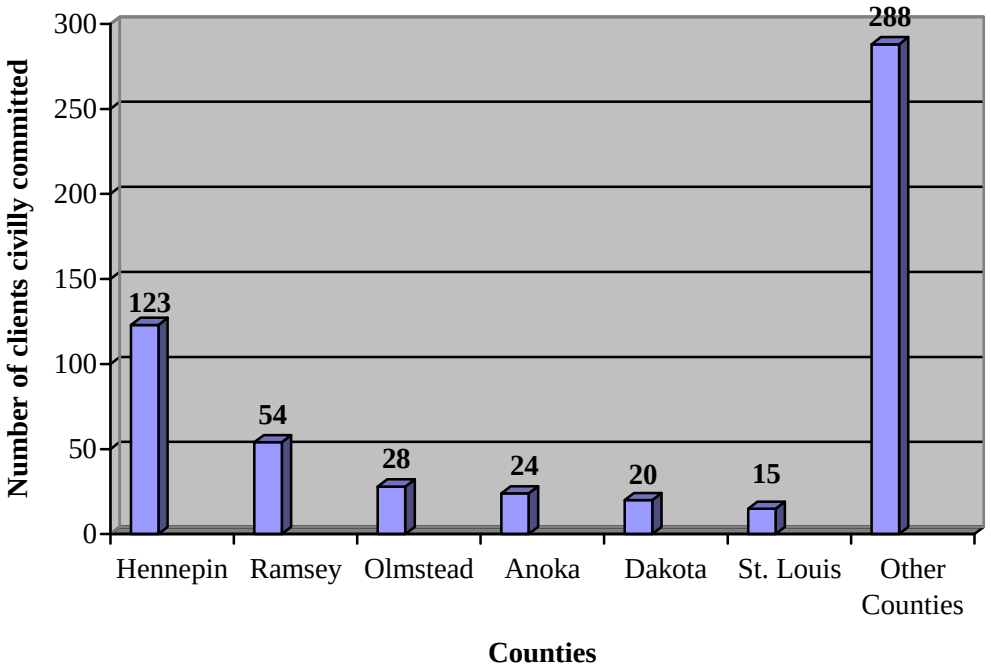
Client Demographics







Top Six Counties for Committment



Population Statistics

If civil commitment is being pursued for an individual, upon expiration of a DOC sentence or a supervised release date, he or she is placed on a judicial hold while the petition is pending. Individuals on judicial holds have the option to remain in a DOC facility, be held in a county jail (210 days), or be admitted to MSOP. As of 01.01.10, MSOP had 15 individuals on hold status.

Clients on judicial hold status within MSOP	15
Clients on judicial hold status in DOC / jails	2
Total clients on judicial hold status	**17**

Currently, the civil commitment process in Minnesota has two phases after a petition has been filed with probable cause. During an initial hearing, the court determines if the individual meets the statutory criteria for civil commitment. If this burden is met, the individual is civilly committed and transferred to MSOP (if the client is not already admitted). Sixty days after this hearing, per statute, MSOP is required to submit a report to the committing court indicating whether or not the client's status remains the same. Specifically, does the client still meet the statutory criteria for civilly commitment? If the court determines there has not been significant change since the initial commitment, the client's commitment is indeterminate and final.

Clients who have been initially committed	22
Clients who have been finally committed	517
Total clients on civil commitment status	**537**

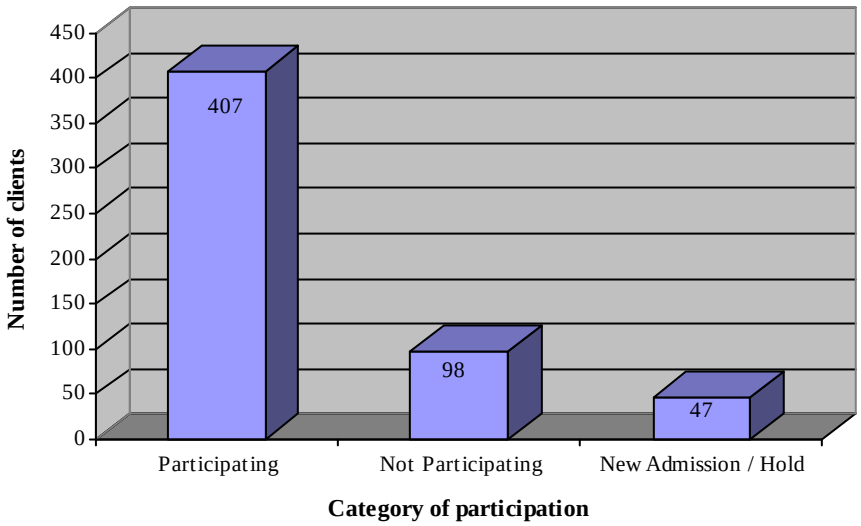
Many clients participating in treatment in MSOP, also remain under DOC commitment on supervised release status. If these clients engage in actions or criminal behaviors which revoke their supervised release status or result in a new conviction, the clients are returned to DOC to serve a portion or all of their criminal sentences. However, they remain under civil commitment and will return to MSOP upon completion of the period of incarceration.

Clients who have been revoked and returned to DOC.	62
Clients who are under civil and DOC commitment in MSOP	217
Total number of dually committed clients	**279**

Treatment participation

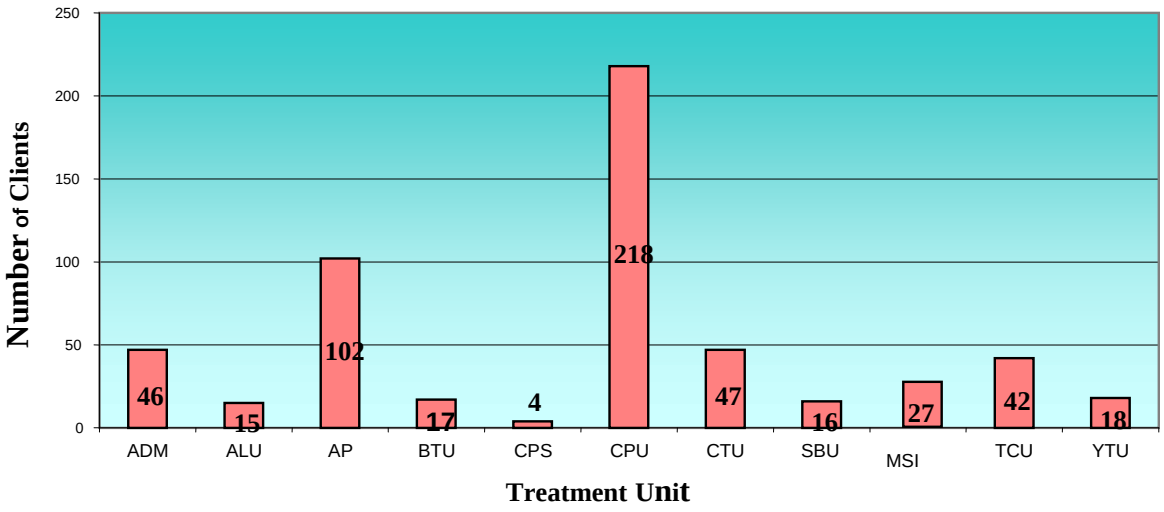
All new admissions are assessed for individualized treatment needs. While on the admissions unit, clients are able to participate in groups geared toward adjustment issues and treatment readiness, as well as, rehabilitative programming. Once the civil commitment process is finalized, and an individuals has participated in the sex offender evaluation process, they have the opportunity to participate in sex offender-specific treatment. Of the clients eligible for sex offender-specific treatment, 80% participate.

Participation in sex offender-specific treatment



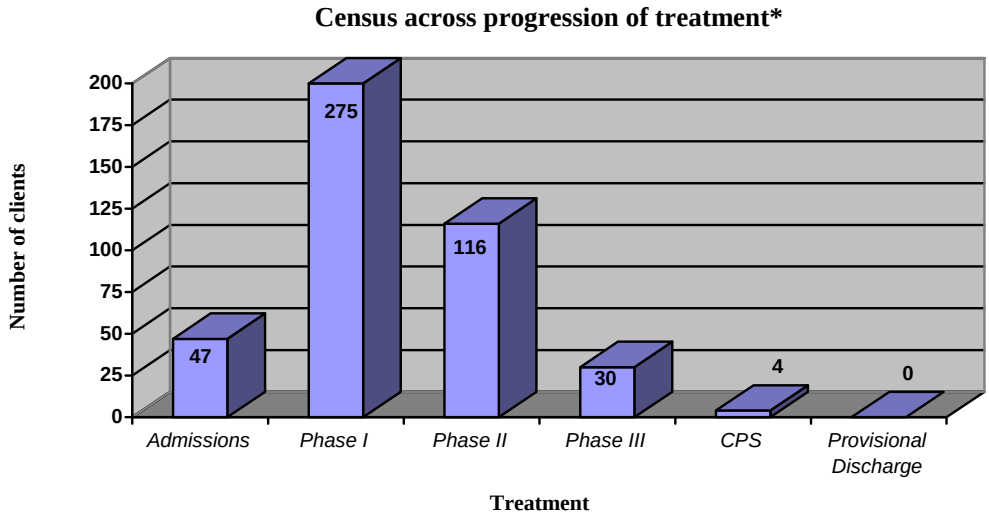
As a result of initial, and ongoing clinical assessments, clients are placed in treatment units appropriate to their individual treatment needs and abilities. The following chart illustrates the year-end distribution of clients across the treatment units. The MSOP population is diverse, and 45% of the clients reside on units that provide specialty programming compared to the 39% of the population residing on units providing Conventional Treatment. The remaining 16% of the population resides on programming units that do not provide sex-offender specific treatment (ADM and TCU).

Treatment Unit Census
01.01.2010
Moose Lake & St. Peter



UNIT	Description	Number of Clients	Location
ADM	Admissions and Intake	46	Moose Lake
ALU	Assisted Living	15	Moose Lake
AP	Alternative Programming	102	St. Peter
BTU	Behavior Therapy	17	Moose Lake
CPS	Community Preparation Services	4	St. Peter
CPU	Conventional Programming	218	Moose Lake, and St. Peter
CTU	Corrective Thinking	47	Moose Lake
SKB	Skill Building	16	Moose Lake
MSI	MSOP Supervised Integration	27	St. Peter
TCU	Therapeutic Concepts	42	Moose Lake
YTU	Young Adults Treatment Unit	18	Moose Lake

Treatment Progression Statistics



*** Does not include 98 non-participants**

Administrative Statistics

Of the 132 MSOP policies in effect, 110 of these took effect in 2009. There are currently 63 new policies or policy revisions in development. Each policy has an assigned drafting chair and drafting committee responsible for the overall development of policy, an ongoing review and update. This provides for integrated line staff involvement and collaboration in the development of MSOP operational practices. The MSOP Policy Committee, which includes representation from executive and facility clinical and support staff, reviews and approves each policy before issuance.

MSOP is operating under a variance from the Department of Licensing. This variance was effective on May 28, 2009. However, the implementation has been incremental due to the need to articulate and develop major policies surrounding admission, high security area, protective isolation status, vulnerable adults, levels of observation, and administrative restriction status, which continue to be refined and adjusted. Many of the policies did not achieve full implementation until November or December 2009. In December 2009, the Department of Licensing visited MSOP to review the effectiveness and implementation of the current variance. It was determined the existing variance is in need of additional clarity and modifications to ensure its applicability to MSOP and the program's ability to achieve maximum compliance with the requirements of the Rule.

Office of Special Investigation (OSI)

In 2009, OSI completed 511 investigations focusing on client misconduct**,** which resulted in various dispositions. There were criminal charges filed in 30 cases (11 from 2009, 19 from prior to 2009), and in 24 cases, clients were revoked and returned to DOC. There were 9,957 incident reports with 16,756 incident reports completed (e.g., there is often more than one incident report per event).

In 2009, 31 clients were returned to DOC for revocations or new convictions. The range for days spent in DOC by MSOP clients in 2009 was 149-1629 days with 513 days being the average length of time spent back in DOC.

Training

With the separation of MSOP from SOS, and the dynamic nature of staffing over the last few years, assessment, planning for and monitoring the training needs of MSOP staff has been a critical objective. Staff training was centered on educating staff about new procedures, practices, and technology as MSOP moved out of the Annex and into the new facility, Complex 1. In 2010, MSOP will measure: 1. obstacles in the completion of staff training, 2. number of, and length of, time spent developing new courses, and 3. outcome data for training.

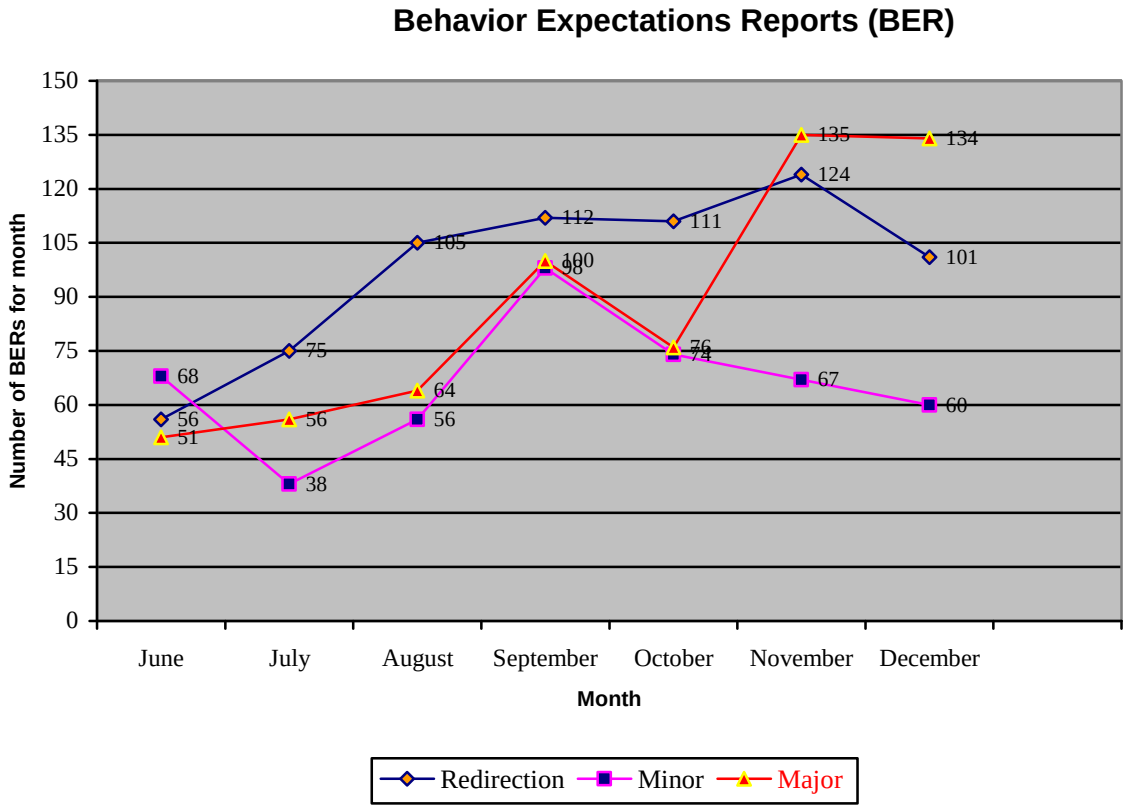
Another major accomplishment was training the majority of the staff on Motivational Interviewing. This philosophy and approach to communication convey respect for the individual needs and progress of clients, facilitates movement through the change process, and often minimizes the escalation of conflict between clients and staff.

Staff Development Accomplishments		
Course	**Staff target for training**	**Number of staff trained**
Complex One and Security Screen Training	285	210
Pat Searches and Unclothes Visual Body Searches	447	303
Investigating Employee Misconduct	40	40
Motivational Interviewing	660	508
Behavioral Expectations	660	581
Boundaries I	793	649
Personal Safety Techniques	660	563
CPR / First Aid	250	180

Behavior Expectations Unit

On June 2, 2009, MSOP initiated the Behavior Expectations Unit. This unit serves to ensures due process and increases consistency in expectations and consequences. This unit began collecting data June, so these data reflect only seven months of 2009.

Behavior Violation	Redirection	Minor	Major	Total
010 Abuse/Harassment	53	50	177	**280**
020 Arson	0	0	0	**0**
030 Assault	0	0	34	**34**
040 Unauthorized Area	33	26	70	**129**
050 Bribery	0	0	2	**2**
060 Contempt	1	0	1	**2**
070. Creating a Fire Hazard	0	0	1	**1**
080 Destruction of Property	9	13	15	**37**
090 Disobeying Staff Directive	76	57	113	**246**
100 Disorderly Conduct	23	30	102	**155**
110 Disturbing Others	26	30	27	**83**
120 Escape	0	0	0	**0**
130 Extortion	0	0	2	**2**
140 Failure to Display/Carry ID	42	24	16	**82**
150 Failure to Comply	477	369	275	**1121**
160 Gambling	0	0	0	**0**
170 Holding Hostage	0	0	0	**0**
180 Homicide	0	0	0	**0**
190. Improper Dress	32	8	7	**47**
200 Inciting/Unlawful Assembly	0	2	1	**3**
210 Interference with Security	35	7	102	**144**
220 Loitering	4	3	0	**7**
230 Lying and Misrepresentation	11	14	25	**49**
240 Interrupting Count	8	2	21	**31**
250 Obstructing Cuff Ports	5	6	18	**29**
260 Unauthorized Tasks	10	6	1	**17**
270 Possession of Contraband	44	23	34	**101**
270.1 Poss. of Contraband- Drugs	0	0	4	**4**
270.2 Poss. of Contraband- Alcohol	0	0	2	**2**
270.3 Poss. of Contraband- Weapon	0	0	5	**5**
270.4 Poss. of Contraband- Money	0	1	4	**5**
280 Riot	0	0	0	**0**
290 Sexual Behavior	5	1	57	**63**
300 Smuggling	1	6	1	**8**
310 Tampering with Security	3	10	20	**33**
320 Threatening Others	6	8	72	**85**
330 Unauthorized Control	141	110	75	**326**
340 Unsanitary Acts	34	36	18	**88**
350 Use of Intoxicants	0	0	4	**4**
360 Visiting Misconduct	1	2	0	**3**
370 Wasting Energy	31	3	7	**41**



Legal Statistics

The MSOP Legal Department is staffed by two licensed attorneys and one legal assistant. One attorney works out of central office in St. Paul. The other attorney and the legal assistant work in Moose Lake.

The attorneys provide legal advice, counsel, legal direction, and supervision to the MSOP management and staff regarding any and all pending, threatened, or potential civil, criminal and/or administrative legal actions. They also coordinate and provide legal advice as necessary to MSOP staff regarding data privacy and security issues.

In addition to supporting the attorneys in litigation, the legal assistant serves as the primary coordinator of all facility admissions and discharges.

The legal department maintains an ongoing relationship with, and serves as the primary liaison to, the Attorney General's Office and local county attorney's offices on all legal matters involving or affecting MSOP.

New Litigation Jan-Dec 2009

Court	Total Number	Type
Carlton County Court	24	22-Habeas 2-Conciliation
Federal District Court	5	
Human Rights	2	
Data Challenge (IPAD)	1	
Court of Appeals	6	4-Appeals 2-Petition for Review
Total	**38**	

Monitor or Closed Jan-Dec 2009

Court	Total Number	Status
Carlton County Court	17	▪ 8 Habeas Corpus petitions were dismissed and/or denied two of those clients whose petitions were denied filed appeals. ▪ 7 Habeas Corpus petitions were dismissed and/or denied and are currently being monitored for an appeal ▪ 2 Conciliation cases were dismissed at the county level but the Joint Claims Committee ordered MSOP to pay the cost of replacing the items.
State District Court	6	▪ 1 case is currently being monitored for an appeal. ▪ 1 case was dismissed and the client has appealed the decision. ▪ 1 case was appealed on a separate issue after a settlement was reached. ▪ 2 cases were dismissed and have been closed. ▪ 1 case was withdrawn by the client
Federal District Court	1	▪ 1 case was dismissed and is being monitored for appeal
Human Rights	3	▪ 3 cases were dismissed
Data Challenge (IPAD)	1	▪ Agreement was made and client withdrew remaining claims.
Court of Appeals	6	▪ The Court granted summary judgment to MSOP in 2 cases. ▪ 2 dismissals were upheld by the Court. ▪ 2 petitions for review were rejected.
Total	**34**	

Section VI

Minnesota Sex Offender Program Evaluation Report Required Under Section 246B.03

In effort to maintain a treatment program that is grounded in current best practices, research, and contemporary theories, MSOP contracted with outside auditors to review the program. This team consists of three professionals who are well respected both nationally and internationally in the area of sexual abuse treatment. As a group, and individuals, they have consulted with similar programs throughout the world. They bring not only a perspective of current practices, but years of professional experience. In 2009, they visited the Moose Lake facility. The goal is to have them visit both sites in 2010. The focus of their consultation is the integrity of the clinical program design. The report was generated as a result of this visit is contained within Appendix 3 of this document.

Appendices

Appendix 1

Matrix Factors	**Criminogenic Needs/ Dynamic Risk Factors**
Group Behavior	Resistance to Rules/Supervision Negative Social Influences Poor Self-Regulation General Hostility Hostility toward Women
Attitude toward Change	Offense Supportive Attitudes
Self Monitoring	Poor Self-Regulation Impulsivity-Recklessness Sexual Preoccupation Deviant Interests, incl. sexual Sexualized Coping
Thinking Errors	Offense Supportive Attitudes General Hostility Hostility toward Women Callousness
Pro-Social Problem Solving	Negative Social Influences
Emotional Regulation	Poor Self-Regulation Impulsivity-Recklessness
Interpersonal Skills	Emotional Congruence with Children Poor Adult Attachment Negative Social Influences
Cooperation with Rules	Resistance to Rules/Supervision
Sexual Functioning	Sexual Preoccupation Deviant Interests, incl. sexual Sexualized Coping
Use of Personal Time	Unstable Work History

Appendix 2
Schedule 1: Client in Conventional Programming, MSOP Moose Lake

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
7:00	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast
		Vocational Work Program	Vocational Work Program	Education Class	Vocational Work Program	Vocational Work Program	Library
8:00							
	Rehabilitative Programming						Rehabilitative Programming
9:00							
10:00							
11:00						Library	
	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
12:00	Count	Count	Count	Count	Count	Count	Count
		Rehabilitative Programming		Living Unit Mtng	Vocational Work Program		Computer Lab Time
1:00	American Indian Pipe and Drum 1p-4p						
			Education Class			Education Class	
2:00							
	Computer Lab Time		Banking	Library			
3:00	Rehabilitative Programming	Treatment Groups		Treatment Groups		Treatment Groups	Every 4th Sat Ht, Wt, and Blood pressure check in Health Servcies
4:00			Education Class		Canteen Linen		
		Library					
5:00	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
	Count	Count	Count	Count	Count	Count	Count
6:00	Volleyball	Computer Lab Time	Rehabilitative Programming	American Indian Group	Rehabilitative Programming	Rehabilitative Programming	
		Rehabilitative programming					
7:00							
8:00				Computer Lab Time	Computer Lab Time		Computer Lab Time
				Rehabilitative Programming	Rehabilitative Programming		
9:00							
10:00	Count	Count	Count	Count	Count	Count	Count

Blue - Vocational, or Educational | Yellow - Optional activities | Green - Sex Offender Treatment Sessions

~Yard times are from 8am until 1/2 hour before sunset ~ Unit computers sign up and use from 6:30a-8:30p ~ Legal computer sign up and use from 6:30a-8:30p

~ If client is Living Unit Representative or a Unit Food Committee representative - those meetings are approx once a month for 1 hour. ~ Independent with all meds

Schedule 2: Client in MSI, MSOP St. Peter

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	Medication	Medication	Medication	Medication	Medication	Medication	Medication
7:00	**Breakfast**	**Breakfast**	**Breakfast**	**Breakfast**	**Breakfast**	**Breakfast**	**Breakfast**
		Vocational Work Program (LeSueur Industries)			Vocational Work Program (LeSueur Industries)		
8:00							
	Campus Walk						Religious opportunities and/or Campus Walk
9:00			Health & Wellness	Health & Wellness or Canteen		Health & Wellness	
10:00			Treatment Groups	Treatment Groups		Treatment Groups	
11:00							
12:00	Medication	Medication	Medication	Medication	Medication	Medication	Medication
	Lunch	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**
1:00	Social Time	Math/Library	Community Outing	Vocational Work Program (screen shop)	Vocational Work Program (screen shop)	Vocational Work Program (screen shop)	Rehabilitative Programming
2:00	Campus Walk	Social Time					
3:00	Outer yard	Community Planning Group					
4:00	Linen Exchange				Living Unit Mtng		
5:00	Medication	Medication	Medication	Medication	Medication	Medication	Medication
	Dinner	**Dinner**	**Dinner**	**Dinner**	**Dinner**	**Dinner**	**Dinner**
6:00	A.A. Health & Wellness	Rehabilitative Programming	A.A. Rehabilitative Programming	Rehabilitative Programming	Social Sport Talk Fitness	Music Mania	Group Social programming
7:00							
8:00							

Blue - Vocational, or Educational

Yellow - Optional activities

Green- Sex Offender –specific treatment

Appendix 3

Minnesota Sex Offender Program Site Visit Report

Site Visitors: James Haaven, Private Consultant, Portland, Oregon; Robert McGrath, McGrath Psychological Services, Middlebury, Vermont; William Murphy, University of Tennessee, Memphis, Tennessee
Location: Minnesota Sex Offender Program, Moose Lake, MN
Dates of Visits: April 7-10, 2009
Date of Report: April 15, 2009

Overview

The Minnesota Sex Offender Program (MSOP) contracted with the consultants to review and evaluate its treatment program. The consultation was a component of MSOP's quality improvement program. This was a follow-up site visit from our previous program reviews in February 2006 and October 2007.

Procedures

During the four day visit, we engaged in the following activities:
• Met in meetings with Jannine Hebert, MSOP Executive Clinical Director, Greg Carlson, MSOP Director at Moose Lake and David Prescott, Clinical Director at Moose Lake;
• Toured the current facility;
• Toured the new facility;
• Attended two Morning Report meetings and six morning Unit meetings;
• Met with the following staff groups without their supervisors present;
o clinical supervisors,
o program psychologists, social workers, and behavioral analysts,
o unit managers, and
o security counselors (two groups);
• Met with three groups of patients (between 4 and 7 patients in each group);
• Attended three treatment groups;
• Reviewed the clinical records of six patients;
• Provided verbal feedback of our findings to Clinical Directors Jannine Hebert and David Prescott; and
• Provided verbal feedback of our findings to a group of 14 senior clinical and administrative directors and managers.

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

Consultation Approach

We evaluated the program against international best practice standards and guidelines in the field. These included national program accreditation criteria used in Canada, Scotland, Hong Kong and the United Kingdom, the Association for the Treatment of Sexual Abusers (ATSA) Practice Standards and Guidelines for the Evaluation, Treatment and Management of Adult Male

Sexual Abusers, and the sexual offender and general criminology "What Works" research literature. Concerning issues where relevant guidelines and standards do not exist, we evaluated the program against common practices in other civil commitment programs and general sex offender programs.

Findings and Recommendations

We were extremely impressed with the amount of work that staff have accomplished since our last site visit. It is clear that staff who are responsible for delivering the program are highly dedicated and are committed to running a program that adheres to best practices.

It is important to note that since our last site visit the program has undergone a considerable amount of change. As of March 2008, MSOP became administratively independent from the State Operated Forensic Services and this has necessitated developing a new intra-structure, including new policies and procedures within a short time frame. As well, new senior operational and clinical staff had to be hired and most are new to the MSOP. Over the last couple of years, MSOP has been constructing a new facility to accommodate an expanding patient population. During this time, many program patients have been housed temporarily in a facility operated by the Minnesota Department of Corrections. In the next couple of months, patients will start being transferred to the new facility. As well, budget cuts have necessitated program restructuring, including reductions in staff.

As noted in our previous reports, an over-arching issue in the program is that no one is being released. This is contrary to the intent of the program, impacts the morale of patients, staff and in the long term this may impact the overall safety of the institutions.

Organization of Findings and Recommendations

The following sections of the report are organized around 12 best practice areas that are linked with effective sex offender treatment programs. We briefly define each key area, assess the program's functioning in that area and make recommendations for continued development. Site

1. Model of Change

The program has an explicit and empirically-based model of change that describes how the program is intended to work.

The program is broadly cognitive-behavioral in nature which is consistent with best practices in the field. The program is moving away from a more traditional cognitive-behavioral relapse prevention model to one that balances a risk management approach with a focus on positive approach goals. The site visit team recommends that the program produce a written model of change available to all staff.

2. Risk and Intensity of Services

The intensity of services is matched to the risk level and treatment needs of the offenders.

By nature, civil commitment programs focus on a high risk population and this is true in the MSOP. The MSOP provides approximately six hours of sex offender specific treatment per week in addition to recreational, educational and vocational opportunities. Sex offender specific treatment generally refers to individual, group, or family therapy directly related to criminogenic needs. The site visitors' experience in reviewing other civil commitment programs is that they typically provide between six and twelve hours of sex offender specific treatment per week.

Therefore, the MSOP's program intensity of treatment is acceptable but in the lower end of the range provided by other programs. Ideally, as resources permit, the program would increase the intensity of sex offender specific treatment by a few hours per week.

3. Treatment Targets

The program assesses offenders' changeable problems that are closely linked to sexual and other offending behavior and targets them in treatment. These are commonly called "dynamic risk factors" or "criminogenic needs."

The MSOP program clearly focuses on criminogenic needs and has made considerable improvement in this area over the last few years. The assessment process at MSOP is focused on identifying criminogenic needs relevant to the individual patient. Treatment plans and therapy notes clearly document that treatment focuses on these criminogenic needs.

4. Responsivity

The program delivers services in a fashion to which offenders can most successfully respond.

This concerns the "responsivity" principle and focuses on how services are delivered. Programs should consider responsivity issues such as offenders' motivation, intelligence, psychopathy, mental illness, and cultural issues. Additionally, therapist style is an important responsivity issue. Greater treatment impact is found when the therapist is firm, fair, direct, warm, and empathetic, and shows an overall concern for the offender's well being.

The program has been sensitive to responsivity issues. The MSOP has developed specific programs for those high in psychopathy, for young adult offenders, for those with significant mental health issues, and those with lower IQ and impaired learning ability. It is recommended that when a patient is transferred to the Behavior Therapy Unit that processes and procedures are developed for the patient's home unit to stay involved with the patient and reaccept the patient after his behavioral problems have been addressed successfully. Observations of groups suggest that therapist and staff treat patients with respect and attempt to engage and motivate patients. Most patients interviewed were complimentary of the skills and style of their therapists.
The introduction of motivational interviewing by David Prescott should provide additional tools to both clinical and direct line staff in this area.

5. Program Sequence

The sequence and spacing of services is logical and responsive to offenders' treatment needs and learning styles.

The program needs to continue it work on developing a logical sequencing of treatment. A well defined program sequence provides staff and patients with benchmarks for determining where an individual is in the program relative to being ready for transition to the community. There is some lack of clarity among patients and staff with regard to patient benchmarks for movement through the program.

Several models and methods exist. For example, many sex offender treatment programs have various phases and a common progression through treatment is as follows: (1) engagement and motivation, (2) treatment interfering behaviors, (3) disclosure and problem identification, (4) skill acquisition, and (5) transition planning. There are other possible models and this is a major focus of David Prescott's current work as the new Clinical Director at Moose Lake.

6. Effective Methods
The program employs methods that have been consistently demonstrated to be effective with offenders.
Programs should be skills oriented and utilize techniques such as cognitive restructuring, training in self-monitoring, modeling, role-play, graduated practice with feedback, and contingency management. In general, more effective programs allocate about half or more of treatment time to skill building interventions.

The MSOP uses a number of skill building activities and this is an area for continued development. The program has a number of psycho-educational modules with treatment manuals. Some of these are better developed than others and they contain varying levels of skill focus. Some of these need updating. The site visit team recommends that staff continue to review and update these manuals with a focus on assuring that they contain adequate skill practice and focus primarily on criminogenic needs.

The "core" treatment group is a significant part of the program. However, there is variability in how this group is delivered among therapists and the amount of time that is spent in this group on skill building and criminogenic needs. Part of this is due to the changes ongoing in the organization and the need for therapists to address day-to-day concerns expressed by patients. However, these groups need to be more standardized to ensure a focus on criminogenic needs and skill building.

The site visit team recognizes the important role that recreation therapy and vocational services have in helping patients develops skills in several criminogenic areas. These services are well developed and are offered during weekdays as well as evenings and on weekends.
The vocational program provides high level skill training that prepares patients for real world work. This is a model program and the strongest one we have seen in a civil commitment program. A challenge will be to ensure a balance between the needs of the vocational program with the primary mission of the MSOP, namely, addressing the sex offender treatment needs of patients. It will also be important, as is planned, to ensure continuation of the program at the St. Peter site.

7. Continuity of Care
Progress that offenders make in the institution is reinforced and strengthened by treatment and supervision in the community.
The program has a clear and thoughtful plan for transitioning patients to the community. Components include the MSI (MSOP community integration) and the CPS (community preparation services) programs. A few patients are now in these later stages of treatment and are preparing for release. The program however still needs to develop more detailed criteria Site for movement through the various levels of care and placement in these transitional services programs.

8. Program Monitoring and Evaluation
The program monitors its operation continuously to ensure that services are delivered as intended, the quality of services are improved, and the effects of services are evaluated.

Processes are in place for monitoring the ongoing functioning of the program. Key staff meet on a regular basis in daily Morning Report meetings, Unit meetings and Shift meetings to ensure the proper function of the program. Quality assurance procedures are in place to monitor a variety of activities including record keeping and debriefing critical incidents. The new administrative structure includes a Director of Research and Assessment and supporting staff. We recommend that this division, in conjunction with the Clinical Director, develop a plan for the clinical monitoring and evaluation of the program. We believe the program is well positioned to conduct research that will improve the functioning of the program and contribute more broadly to the sex offender assessment and treatment field.

9. Staff Training Supervision

Staffing levels are adequate and staff are appropriately selected, trained, and supervised.

We found a staff that is dedicated and committed to the program. The new clinical leadership team brings several strengths to the program. Jannine Hebert has extensive administrative and clinical experience in corrections and the sex offender field. David Prescott is a nationally recognized expert in sex offender assessment, treatment and program development, has authored many publications in the field, and brings extensive experience to his position at MSOP, especially from his prior work in a well respected sex offender civil commitment program. The staff has received excellent training from leaders in field. Many staff attend the MN ATSA yearly meeting and the ATSA national conference. This is a very strong aspect of the program. The program provides ongoing clinical supervision and the recent establishment of clinical supervisor positions is a program strength. In addition, clinical staff are involved in morning Unit meetings with direct line staff, Morning Report and joint meetings with unit directors. In addition there are regularly scheduled meetings of all clinical staff. This process of communication across administration, clinical staff and direct line staff stands above other programs we have reviewed. The planned clinical staffing level when Unit 1 opens seems reasonable. It is hoped that these positions will continue to be budgeted and can be filled. With an increased census, clinician workload is increasing beyond capacity. The ratio of security counselors to patients has decreased markedly over the last year and this makes it difficult for these staff to be as involved in the therapeutic aspects of the program as occurs in many of the other civil commitment programs. As the clinical leadership team develops new direction for the program, it is important to involve clinical supervisors and clinical staff further in the planning and implementation process.

10. Service Documentation

Staff document services in an appropriate, thorough, and timely manner.

We reviewed six patient records and found that they were in good order. In particular, assessment reports, treatment plans, and progress notes were all clearly linked to the patients' dynamic risk factors. This is an improvement over previous visits and represents a high quality of service documentation. Increased emphasis on approach goals will further improve treatment planning.

The charting responsibilities of security counselors are currently under review. Security staffs' observations directly recorded in the record can contribute in a variety of ways, including to yearly assessments where such information provides a more comprehensive picture of patient's

progress or lack of progress. The site visit team supports continued exploration of ways security counselors can directly document significant clinical material in patient records.

11. Facility and Treatment Environment

The facility and treatment environment is safe, secure, and therapeutic.

The current building was purposefully built as a program facility, whereas the new facility is more typical of a prison in design. Although in the new facility the use of carpeting, natural light and other features make the living units more appealing than many typical prisons, the size of the units (68 and 98 beds) are much larger than ideal to operate a therapeutic milieu. The current number and size of the group treatment rooms in the new facility is inadequate.

Patients who assault staff or commit other criminal acts are now being successfully referred for prosecution and many are being convicted and sentenced in criminal court. This has increased staff safety and reduced patient acting out. Although we see this as positive, there is a stronger security presence within the facility than we have seen in other civil commitment programs. An ongoing issue will be to maintain a safe and secure facility without undermining the therapeutic goals of the program.

Due to reduced staffing levels and an increased focus on security issues over the last several months, security counselors are no longer involved in psycho-education and treatment groups in the program. Many security counselors told us that focusing just on security made their job simpler but less rewarding. Several also told us that as the number of patients that they have to supervise has increased markedly. They are concerned that they will not be able to learn about the behavior patterns of patients on large units in order to better mange their behavior. High caliber civil commitment programs integrate security counselors into treatment activities. As resources are available, we recommend that security counselors return to being more involved in therapeutic groups and activities, especially in the Corrective Thinking, young offender, and mental health program units.

The units and group rooms do not have therapeutic material on the wall, such as posters describing treatment concepts. The site team recommends that the program post such materials to enhance the therapeutic nature of the living area and group treatment room environments. This is common practice in other civil commitment programs across the country.

12. Administrative Structure and Program Organization

The administrative structure and program organization supports the healthy functioning of the program. Staff communicate effectively in order to ensure that offenders' services are coordinated.

A strong administrative structure is in place and processes ensure ongoing staff communication. As previously noted, these include daily Morning Report meetings, Unit meetings and Shift meetings. Each patient is staffed at least quarterly and undergoes a comprehensive yearly review.

As previously noted, the MSOP has undergone a number of changes and has new clinical leadership. The leadership has a number of positive ideas about the direction of the program. It is our recommendation that an action plan be developed with time frames for the next year to implement changes