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Chris Steller

From:	Kochanski, Alexis R (DHS) <Alexis.Kochanski@state.mn.us>
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Cc:	LaRissa Fisher; Andrea Todd-Harlin; Bailey Strand; Tom Brennan; Inderia Falana; Elspeth Cavert
Subject:	4/15 Submission of DHS Legislative Reports
Attachments:	MSOP Legislative Report_Quarterly 2018_final.pdf; FY19 2nd Quarter Report on AMRTC MSH CBHHs.pdf; ICHRP Leg. Report.pdf

Dear Legislators,

Please find the following legislatively mandated reports attached:

1. Minnesota Sex Offender Program: Annual Performance Report (2018)

2. Quarterly Report on Anoka Metro Regional Treatment Center (AMRTC), Minnesota Security Hospital (MSH) & Community Behavioral Health Hospitals (CBHH)- Second Quarter FY2019

3. Integrated Care for High Risk Pregnancies

Please let me know if you have any questions or how I can be of further assistance.

Thank you.

Alexis Russell Kochanski, MPH
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Sent:	Monday, April 15, 2019 6:18 PM
To:	Rep.Tina Liebling; Rep.Rena Moran; Rep.Joe Schomacker; Rep.Debra Kiel; James Nobles; Frans, Myron (MMB); Chris Steller
Cc:	Krysta Niedernhofer; Alyssa Fritz; Pat McQuillan; Chris McCall; Danyell Punelli; Doug Berg; Elisabeth Klarqvist; Joe Durheim; Randall Chun; Sarah Sunderman
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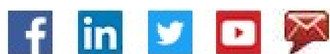

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DHS-6677C-ENG 2-16

Legislative Report

Minnesota Sex Offender Program: Annual Performance Report (2018)

Direct Care & Treatment Division

March 6, 2019

For more information contact:

Minnesota Department of Human Services
Minnesota Sex Offender Program
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St. Paul, MN 55155-0992

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For accessible formats of this information or assistance with additional equal access to human services call 651-431-5800, or use your preferred relay service.

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

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I. Executive Summary

The Minnesota Sex Offender Program (MSOP) provides comprehensive programming to individuals who have been court-ordered to participate in sex offender specific treatment. Clients are civilly committed by the courts and placed in treatment for an indeterminate period of time, usually following their release from prison. As of December 31, 2018, there were 740 MSOP clients in St. Peter and Moose Lake. There were also 21 clients on provisional discharge and currently living in the community.

The ongoing Karsjens federal class action lawsuit continued to play out in 2018. Filed in 2011 by clients of the Minnesota Sex Offender Program (MSOP), the case resulted in a trial in 2015 followed by court orders and several appeals since that time. In February of 2018, U.S. District Judge Donovan Frank dismissed the remaining outstanding claims in Phase I and II of the lawsuit. The clients have now appealed to the 8th Circuit Court of Appeals.

Despite external events, MSOP continues to provide comprehensive sex offender treatment in a safe and therapeutic environment with a voluntary 85 percent client participation rate. Clients are demonstrating progress, making changes, and advancing through treatment as evidenced by the increasing numbers of clients in the later phases of treatment, court-ordered transfers to Community Preparation Services (CPS), and court-ordered provisional discharges into the community as well as three full discharges.

Phase I of the approved 2015 bonding request was completed in 2016, and MSOP opened a 30 bed wing for clients being transferred by the Supreme Court Appeals Panel (SCAP) to CPS. CPS is a less restrictive alternative setting outside the secure perimeter on the lower campus in St. Peter and has operated since 2008. Due to that expansion, MSOP has 89 total beds in the unlocked facility. It has been filled to capacity since the addition opened in 2016. Bonding for Phase II was in the Governor's budget for both the 2017 and 2018 legislative sessions. Bonding that project would have expanded CPS even further to accommodate those clients that SCAP continues to grant transfer orders for. The waitlist for clients to move to CPS currently is at 36 clients. Without additional bed space and infrastructure added outside the secure perimeter, court orders for transfer are not being adhered to, at this time.

Commitment to staff safety is exemplified by the Minnesota Safety Council Meritorious Achievement Award in Occupational Safety awarded to the St. Peter program site for the 6th consecutive year and the Moose Lake program site received the Meritorious Award for the 4th consecutive year. In addition, St. Peter site for MSOP was recognized for reaching an outstanding milestone at that facility in 2018. No time was lost from injuries for an entire year. All staff are to be commended for their efforts in maintaining a culture of safety.

Once again this past year, our Employee Engagement Committees at MSOP participated in successful fundraising across sites. The program raised over $10,000.00 to donate to the State of Minnesota's Combined Charities program.

MSOP's interdisciplinary teams continue to maintain a strong infrastructure for a therapeutic environment supportive of client change. The 5th annual St. Peter Family Support Day was held two

separate days accommodating increased client participation with this critical treatment component ensuring clients have support networks while in treatment and while reintegrating into the community. Changes were made this past year within clinical leadership which was an opportunity to promote stability and professional development. This past year we explored and implemented numerous cost savings ideas, time and program efficiencies, and instituted streamlining processes across MSOP departments.

In 2018, fifteen clients with orders for provisional discharge moved into various Minnesota communities where they are closely monitored and managed by MSOP reintegration agents. Two clients were fully discharged from civil commitment this past year. There currently are a total of 21 clients on provisional discharge in the community. A positive adjustment, continuing with outpatient treatment, having ongoing supervision, and establishing a support system, are all necessary and important for successful reintegration.

Strengthening our therapeutic living environments, ensuring program quality and integrity, growing as a learning organization, encouraging ongoing employee engagement and maintaining our priority and responsibility to safety and security, are the values we are invested in and continue to promote. MSOP highlights for 2018 contained in this report reflect continued focus on our mission to promote public safety by providing comprehensive treatment and reintegration opportunities for civilly committed sexual abusers.

II. Background

M.S. 246B.035 requires the electronic submission of an annual performance report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over funding for the Minnesota Sex Offender Program (MSOP) by January 15 of each year. During the 2016 legislative session, a proposal for extending the report's due date to February 15 of each year was approved. This assures a complete and accurate report that reflects all data and statistics of the entire reporting year.

The statute specifies that this report include:

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

This program evaluation occurred in December 2018.

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

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

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

III. Program Overview

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

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

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

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

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

Strategic Mission

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

Priorities

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

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

MSOP Strategic Goals and Outcomes

Therapeutic Environment

Goal: To further develop, complete, and implement the Community Living Project at MSOP.

Outcome: The Community Living Project (CLP) is a philosophy based on developing a therapeutic community as an approach to maintaining a healthy treatment environment in a residential setting. This multi-step initiative was designed to meet the specific and unique needs of the MSOP clientele. Numerous interventions and enhancements were considered by the project team which were empirically based in literature and identified as best practice within the sex offender treatment field. CLP theory promotes clients taking personal responsibility for daily issues and problems, skill-building to problem solve, and maintaining safe and positive behaviors in the living environment. The project was comprised of four primary areas which included conflict resolution, a tier privilege system, behavioral expectations unit re-design, and a "staff toolbox" to utilize in challenging situations. This past year, the new tier system was rolled out and fully implemented. All clients and all staff across MSOP received training which was a major undertaking. The last area that will now be further developed and reach completion is the staff toolbox component for 2019. Once implemented, the entire CLP will be operational. We have already experienced and observed the positive impact this project has had on our therapeutic communities within our facilities at MSOP.

Learning Organization

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

Outcome: This past year several clinicians and leadership were asked to provide training and present at local conferences in Minnesota as well as at a national conference in Vancouver, Canada. Those organizations, where MSOP was represented, included the state and national Association for the Treatment of Sexual Abusers (ATSA), the Sex Offender Civil Commitment Program Network (SOCCPN), the Sex Crimes Investigator Association (SCIA), and the Massachusetts ATSA chapter. In addition, every fall of each year, the MSOP administration and legal managers host an event and presentation to county and defense attorneys, risk assessment examiners, Special Review Board members, Supreme Court Appeals Panel judges, and others. In 2018, there were approximately 140 attendees. Planning has begun for the upcoming 2019 event. The purpose of this event is to provide current information about the program, legal issues, and reintegration of MSOP clients as well as civil commitment issues both for MSOP and for other Direct Care and Treatment programs. Continuing to seek out opportunities to provide education and information to the general public, legislators, judicial branches, and others will increase awareness about this population and enhance public safety.

Program Integrity

Goal: To design and implement program enhancements for our Alternative Program which serves clients with intellectual disabilities and cognitive deficits at our St. Peter site.

Outcome: In the past year, all elements of our refinement project were achieved, including problem identification, tailored treatment interventions for approximately 100 clients, and implementation of the necessary changes in programming. Clinical “targets” were developed for achievable goal setting, daily and weekly, which were organized into the Alternative Program’s new five individual need areas. Revamping how unit community meetings are facilitated took place as well as refining how core therapy groups include a variety of activities that correlate with the “theme of the day”. Comprehensive training occurred for staff working with clients in the Alternative Program. The Fidelity department is now developing tools to measure effectiveness of these treatment changes.

Responsibility to the Public

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

Outcome: We now supervise, monitor, and provide case management services for 21 individuals released into the community. In 2018, 15 clients moved from MSOP into various communities after being granted provisional discharge by the Supreme Court Appeals Panel (SCAP) in 2017 - 2018. Two of the 15 had their provisional discharges revoked due to non-criminal violations of their conditions. Continuing our search for appropriate housing for clients was a primary focus and ongoing challenge in 2018. Based on client needs, available resources, and the individual provisional discharge plan that outlines specific conditions, the appropriate living environment is sought. Residency restrictions and ordinances in our state along with other barriers often interfere with placement efforts by MSOP. To assist in the overall transitional process, Community Preparation Services (CPS) and the Reintegration department have enhanced collaboration and communication as clients leave CPS and move into the community. This important “hand-off” is a critical component of deinstitutionalization and acclimation to the outside world. It is the program’s highest priority and public responsibility to assure there is gradual, safe, and intentional reintegration by developing and implementing

solid policies and procedures that govern our practices to include assisting in job searching with clients, helping clients form a positive support network, working with aftercare organizations, and overseeing outings and gradually increased liberties for clients. The Reintegration department within our program is still in its infancy. However, a solid foundation has already been built with clear safeguards, precautions, and research-based best practice models of sex offender supervision.

IV. Treatment and Model Progression

Program Philosophy and Approach

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

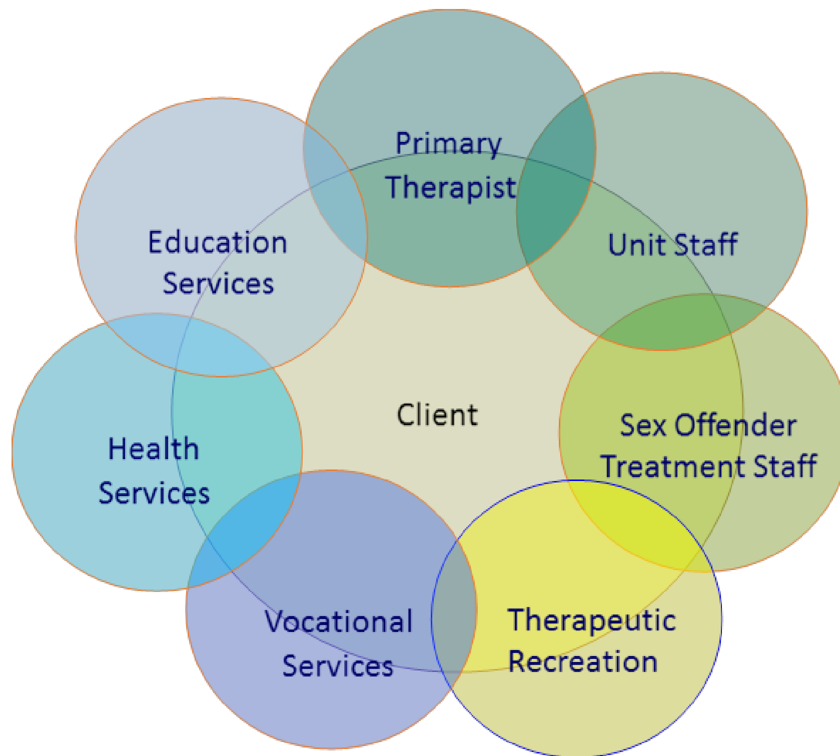
Each client participating in treatment is guided by an individualized treatment plan that defines measurable goals. These goals are updated as the client progresses through treatment.

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

Comprehensive and Individualized Treatment

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

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



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

Treatment Progression

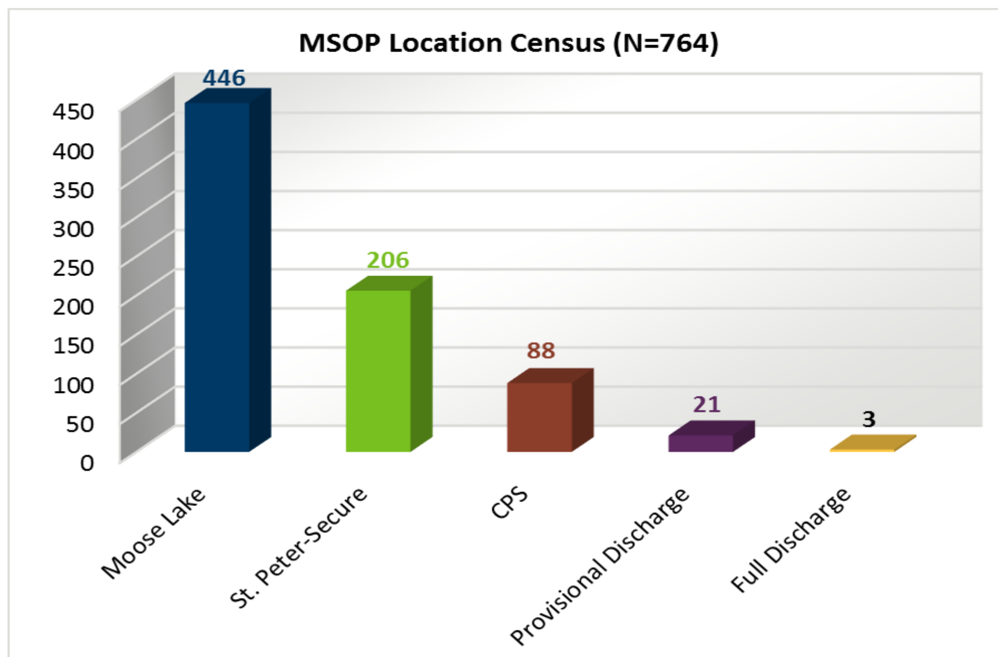
Clients address their own individual risk and treatment needs by adhering to their Individualized Treatment Plans. They attend psychoeducational modules based on their treatment needs and core groups. On a quarterly basis, all clients are reviewed on MSOP matrix factors, which are based on the criminogenic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

The matrix factors are:

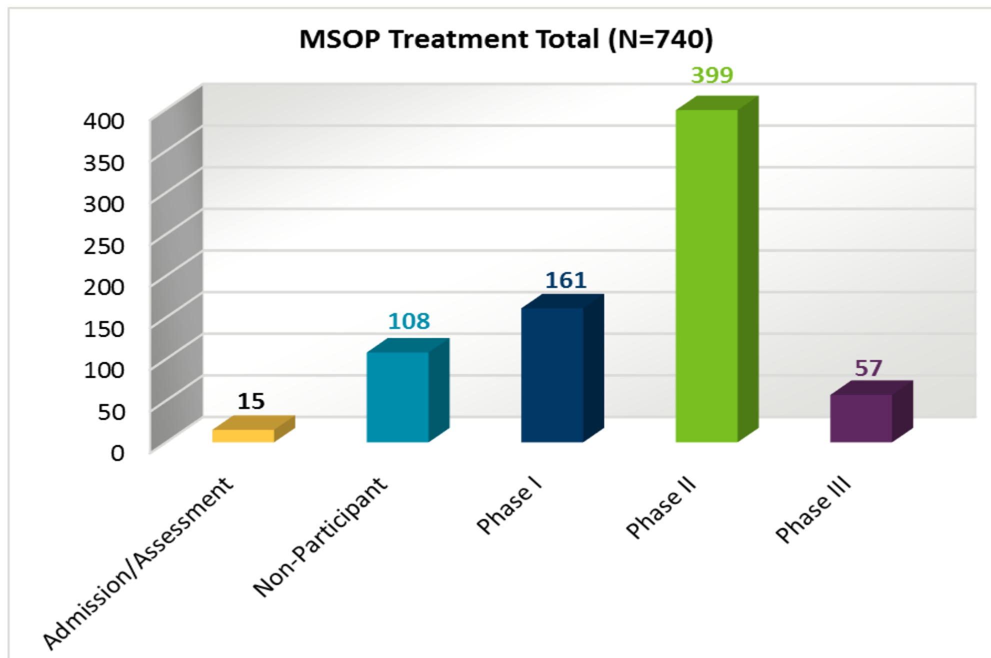
- Group behaviors
- Attitude to change
- Self-monitoring
- Interpersonal skills
- Sexuality
- Cooperation with rules and supervision

- Healthy lifestyle
- Life enrichment
- Thinking errors
- Prosocial problem solving
- Emotional regulation

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



Note: Chart Data as of 12/31/2018



Note: Chart Data as of 12/31/2018

V. MSOP Treatment at the Department of Corrections

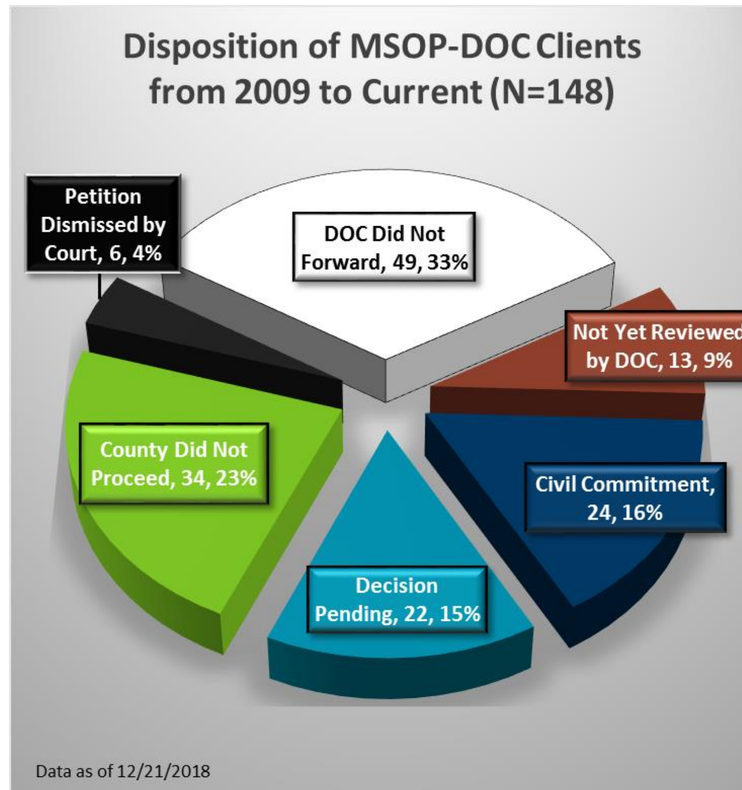
The MSOP operates a collaborative, 50-bed, sex offender treatment program located at the Minnesota Correctional Facility in Moose Lake. This program provides sex offender treatment similar in scope and treatment design to the MSOP-Moose Lake facility. Program participants are serving their correctional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

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

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

There have been 198 clients admitted to the MSOP-DOC program since 1/1/2009. As of Dec 21, 2018, there were 50 clients in the program and 148 clients discharged from the program. Since the beginning of the 4th quarter of 2018, there has been one additional client admitted to the program.

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



VII. Community Preparation Services and Reintegration

Community Preparation Services

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

Established in 2008, the program has experienced tremendous growth in the past few years. In 2016, a total of 43 clients were granted transfer orders from SCAP to CPS. All 89 beds were filled to capacity. In

2017, another 31 clients received transfer orders from the courts. However, there are no available beds at CPS so many of the clients with transfer orders have been unable to move and therefore remain inside the perimeter. In 2018, 22 clients received transfer orders also. Again, due to bed capacity, a waitlist remains.

Phase I of the bonding project to expand beds at CPS was completed in 2016 which provided 30 additional beds to that facility. However, due to continued transfer orders from the courts, CPS immediately filled its bed capacity. Phase II of the bonding bill was requested at both the 2017 and 2018 legislative sessions to expand CPS by 50 additional beds as well as renovate other space to provide the needed services outside the secure perimeter for those clients transferred by the court. However, those bonding requests were not passed by the legislature.

Reintegration

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

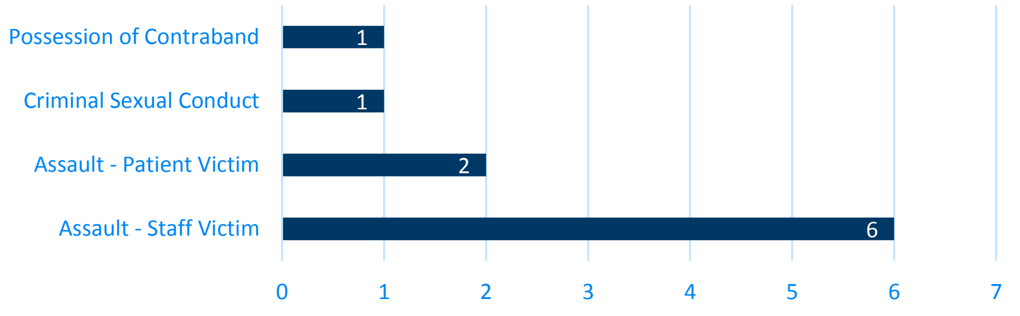
In 2018, a total of 9 clients were granted *new* provisional discharge orders, two were granted full discharges, and 15 moved to the community. Currently there are 21 clients living in communities in Minnesota. The court-ordered Provisional Discharge Plan is based on the individual needs of clients. The MSOP reintegration agents provide close supervision to safely manage and monitor clients on provisional discharge.

VIII. Office of Special Investigation

The Office of Special Investigations (OSI) provides the Direct Care and Treatment program at DHS with coordinated investigative services with the goal of aiding staff in providing a safe and secure treatment environment and to enhance public safety. In the event illegal activities are suspected, OSI is responsible for conducting an investigation and providing comprehensive investigative reports to local law enforcement. Responsibilities of OSI include the investigation of suspected criminal activity, the gathering of intelligence data for program administrations, conducting covert surveillance of clients who have community privileges and those on provisional discharge, investigating circumstances that pose a threat to the security of a program facility, and serving as the official liaison with local, state, and federal law enforcement agencies.

From January 1, 2018 to December 31, 2018, OSI conducted 167 investigations, including127 for MSOP, 39 for Forensic Services (FS), and one for Community Based Services (CBS). Of the 167 cases, 13 were referred for criminal charges (10 for MSOP and three for FS), with charges being filed in 10 cases (8 for MSOP and two for FS). The number of cases referred and cases charged may increase as there are cases from 2018 that have not reached a determination for criminal charges.

OSI also provides information to the Department of Corrections (DOC) regarding clients who are not compliant with their Conditions of Release. In 2018, OSI had 22 cases for MSOP that were referred to DOC for revocation. Of the 22 cases, 15 MSOP clients were returned to DOC for violations of conditional release, 6 MSOP clients had their conditions restructured, and one case remains open.



IX. Program Per Diem and Fiscal Summary

	FY 2019	
Description	**Approp. $$**	**Per Diem**
Direct Costs		
Clinical	$ 21,724,484	81.53
Healthcare and Medical Services	$ 6,546,212	24.57
Security	$ 35,704,826	134.00
Community Preparation Svcs	$ 7,070,100	26.53
Dietary	$ 1,704,974	6.40
Physical Plant & Warehouse	$ 7,111,115	26.69
Program Support	$ 6,414,386	24.07
Total Direct Costs	$ 86,276,098	323.79
Operating Per Diem		*$ 324*
Indirect Costs		
Statewide Indirect	$ 129,020	0.48
DHS Indirect	$ 3,086,000	11.58
Building Depreciation	$ 4,216,564	15.82
Bond Interest	$ 5,670,200	21.28
Capital Asset Depreciation	$ 93,745	0.35
Total Indirect Costs	$ 13,195,530	49.51
Total Costs	$ 99,471,627	373.30
Average Daily Census (ADC)	730	
Published Per Diem Rate		$ 373

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

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

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

MSOP Per Diem

While there are 21 civil commitment programs (20 state programs and one federal program) in the country, there is no uniform method for calculating the per diem cost of program operations. A survey conducted by MSOP Financial Services revealed that most programs do not include all costs associated with operating and maintaining a program. MSOP uses a comprehensive per diem calculation that includes all direct and indirect costs, including costs incurred by the state for bonding and construction of physical facilities. This all-inclusive per diem for fiscal year 2018 is $373.

X. Annual Statistics

Current program statistics through December 31, 2018 are listed below.

- Total MSOP Clients: **740**

Clients by Location	Count	Percentage
Moose Lake	446	60.3%
St. Peter-Secure	206	27.8%
CPS	88	11.9%

Clients by Age	Count	Percentage
21 - 25	6	0.8%
26 - 35	100	13.5%

36 - 45	183	24.7%
46 - 55	190	25.7%
56 - 65	178	24.1%
Over 65	83	11.2%

Age Ranges:

- **Youngest:** 23 years
- **Oldest:** 87 years
- **Average Age:** 50 years

Clients by Race	Count	Percentage
American Indian/Alaskan Native	54	7.3%
Black/African American	108	14.6%
Other/Unknown	37	5.0%
White/Caucasian	541	73.1%

Clients by Education	Count	Percentage
Elementary School	19	2.6%
Some High School	52	7.0%
GED	223	30.1%
High School Degree	334	45.1%

High School Degree and GED	8	1.1%
Some College	40	5.4%
College Degree	14	1.9%
Unknown	50	6.8%

Commitment Type	Count	Percentage
PP Final	44	5.9%
SDP Final	420	56.8%
SPP Final	10	1.4%
SPP/SDP Final	255	34.5%
Judicial Hold	11	1.5%

Commitment County	Count	Percentage
Metro*	302	40.8%
Non-Metro	438	59.2%

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

Population Statistics

Admissions	Count
New Admissions	23
Transfers In	43
Total Admissions	66
Departures/Transfers	
Transfer – Provisional Discharge	15
Transfer – DOC Revocation	15
Transfer – Forensic Nursing Home	13
Transfer – New Criminal Sentence	3
Departure - Death	4
Departure – Court Order/Amended Hold	2
Total Departure/Transfers	52
Net change (Admissions – Departures/Transfers)	+14

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

Clients Pending Civil Commitment	Count
Clients on judicial hold status in the MSOP	11
Clients on judicial hold status in the DOC/Jails	4
Total on judicial hold status	15

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

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

As of December 31, 2018, there were 17 clients dually committed and currently residing in DOC or federal prison.

Dually-Committed Clients:	Count
Clients who are under civil and DOC commitment in the MSOP	151
Clients who are under civil commitment and in a DOC or federal prison	17
Total number of dually committed clients as of December 31, 2018	168

Clinical Statistics

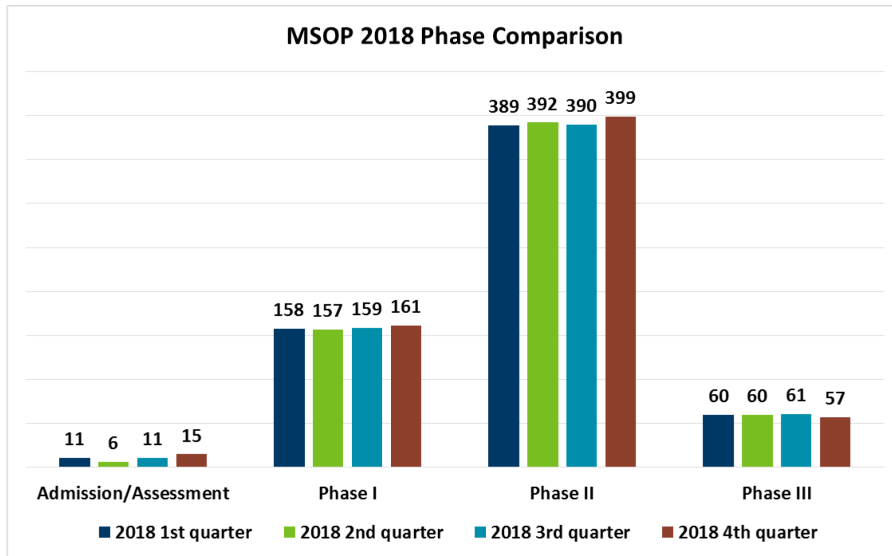
Treatment Participation

All new admissions are assessed for individualized treatment needs. While on the admissions unit, clients are able to participate in groups geared toward adjustment issues and treatment readiness as well as rehabilitative programming. Of the clients eligible for sex offender-specific treatment (725), approximately 85 percent were participating at the end of 2018.

Once the civil commitment process is finalized, an individual is encouraged to participate in treatment. If the individual chooses to engage in treatment, a sex offender assessment is completed and an Individualized Treatment Plan is developed to address unique needs.

Treatment Progression

The phase progression data show how clients are progressing through the three treatment phases. The chart below represents the treatment progression of clients over the past calendar year. Note, clients granted provisional discharge are not included in this chart.



The following chart illustrates the 2018 distribution of clients across the treatment units. The MSOP population is diverse with 20 percent of the clients residing on units that provide specialty programming while 78 percent reside on units providing conventional treatment. The remaining two percent of the population resides on the Admissions/Assessment unit, which does not provide sex-offender specific treatment.

Treatment Unit	Location	Count	Percentage
Admission/Assessment	Moose Lake	15	2.0%
Alternative Programming	St. Peter	98	13.2%
Assisted Living	Moose Lake	20	2.7%
Behavioral Therapy	Moose Lake	27	3.6%
Conventional Programming	All 3 sites	580	78.4%

Clinical Service Hours

Clinical service hours at the MSOP include both clinical treatment hours and clinical programming hours. Clients participating in treatment are scheduled for treatment hours based on their individual treatment needs and their treatment phase. The MSOP program design offers Phase I clients a minimum of eight hours of treatment each week. Clients in Phase II and Phase III are offered a minimum of ten hours per week. Clinical

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

In addition to weekly treatment hours, clients are offered the opportunity to participate in clinical programming. Clinical programming hours are comprised of educational, therapeutic recreation, vocational, and volunteer services. Assignment to programming is determined by the client's treatment phase and individual needs. An example of the minimum total clinical service hours offered to clients, based on their treatment phase, is provided in the table below:

Estimated Weekly Hours of Clinical Service by Phase

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

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

In an effort to maintain a treatment program that is grounded in current best practices, research, and contemporary theories, MSOP contracts with outside auditors to review the treatment program. This team consists of three professionals who are well respected, both nationally and internationally, in the area of sexual abuse treatment. Individually and as a group, they have consulted with similar programs throughout the world. They bring not only a perspective of current practices, but also years of professional experience. The observations, feedback and recommendations in the annual site visit report are reviewed and discussed with the auditors at the end of their visit. The report is reviewed in subsequent meetings with MSOP leadership and incorporated into quarterly and annual program goals as needed.

Minnesota Sex Offender Program Site Visit Report 2018

Site Visitors: Robert McGrath, McGrath Psychological Services

- Middlebury, Vermont

William Murphy, University of TN Health Science Center

- Memphis, Tennessee

Jason Smith, Assessment & Counseling Associates West

1. Des Moines, Iowa and Middleton, Wisconsin

Location: Minnesota Sex Offender Program, Moose Lake, Minnesota

Dates of Visits: November 12-16, 2018

Date of Report: December 3, 2018

Purpose and Overview

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

During the current review, we spent three and one-half days at the Moose Lake site. While we were on site, we reviewed and discussed our initial findings with Jannine Hebert, MSOP Executive Clinical Director, and Peter Puffer, Clinical Director at Moose Lake, for one hour on November 16, 2018. We again reviewed and discussed our initial findings with senior managers at both sites via videoconference for one hour from the Moose Lake site on November 16, 2018.

Evaluation Request

During the current site visit, the MSOP requested that we evaluate two aspects of the program at Moose Lake. First, we were asked to evaluate the results of efforts the program has made to improve cohesion and collaboration within and between departments. MSOP leadership have invested considerable time and resources in this area as it is likely to improve the quality of services provided and the overall operation of the program. Second, we were asked to evaluate the provision of group treatment services in the program with a focus on how well it is adhering to best practices in this area. MSOP leadership have ensured that group treatment staff have received ongoing clinical supervision and specialized training in group facilitation to improve the quality of clinical services within the program.

Procedures

We reviewed the following written materials:

- Organizational Charts
- MSOP Quarterly Reports, 3rd quarter 2018
- Training materials from Steve Sawyer and Jerry Jennings GIFR webinar "Group Therapy with Sexual Abusers."
- Recent MSOP Site Visit Reports

During the site visit we engaged in the following activities:

- Attend the Moose Lake Morning Meeting
- Met in small group and/or individual meetings with senior management, including:
  - Nancy Johnson, MSOP Executive Director
  - Jannine Hebert, MSOP Executive Clinical Director
  - Peter Puffer, Clinical Director
  - Kevin Moser, Facility Director
  - Terry Kneisel, Assistant Director
  - Ann Linkert, Security Director
  - Jaime Wuori, Clinical Program Manager
  - Nikki Boder, Director of Medical Services
  - Kathryn Schesso, Associate Clinical Director
  - Nancy Stacken, Associate Clinical Director
  - Courtney Menten, Associate Clinical Director
- Met with the following staff groups without their supervisors' present:
  - Clinical Supervisors (3 individual meetings)
  - Clinicians (3 individual meetings)

- Treatment Psychologists (2 individual meetings)
- Program Managers (1 group meeting with 3 managers)
- Unit Directors/Group Supervisors (1 group meeting with 4 supervisors)
- Behavior Expectations staff (1 individual meeting)
- Education and Recreation staff (1 group meeting with 2 staff)

- Attended 6 core group therapy sessions
- Attended 3 psychoeducational module group sessions
- Attended 2 CREST meetings (2 different units)
- Attended 2 community meetings (2 different units)
- Attended 1 clinical meeting
- Attended 1 placement meeting
- Attended 1 unit morning meeting
- Conducted informal unscheduled interviews with direct line unit staff
- Conducted informal unscheduled client interviews across the programs while walking through the facility and before and after attending group treatment and psychoeducation sessions, community meetings, and CREST meetings.

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

Consultation Approach

We evaluated the program against best practice standards and guidelines in the field. These included the Association for the Treatment of Sexual Abusers (ATSA) Practice Guidelines for the Evaluation, Treatment, and Management of Adult Male Sexual Abusers and the sexual offender and general criminology "What Works" research literature. Concerning issues where relevant guidelines and standards do not exist, we evaluated the program against common practices in sex offender programs, in particular other sex offender civil commitment programs.

Findings and Recommendations

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

Cohesion and Collaboration Within and Between Departments

Strengths

1. MSOP administrative and clinical leadership have a strong commitment to working together collaboratively as a cohesive team and have provided structure and resources for further development and propagation of this mission throughout the facility.

2. Educational posters are displayed throughout the facility that support cohesion and collaboration within and between departments.

3. Most unit clinical and operations staff report having a cohesive and collaborative working relationships with their teams. Staff commonly expressed deriving work satisfaction from the support they receive and interactions they have with team members.

4. In the group discussions with teams at different leadership levels in the organization, there was a consistent demonstration of openness, comradery, and a willingness to share the strengths and barriers of their groups.

5. MSOP administrative and clinical leadership are attuned and committed to identifying areas for improvement and implementing changes that impact cohesion and collaboration within and between departments.

6. Departments within the facility collaborate with each other in many ways in order to provide coordinated and quality services to clients. Examples include the following:
    a. Unit security staff regularly attend unit community meetings and various other clinical meetings with clinical staff to plan and coordinate services for clients.
    b. Most nurses are assigned to one or more residential units to provide medical services, as appropriate, on the units. This enables nurses to get to know the individual medical needs of clients on those units and enhance client medical care.
    c. Each recreational staff member is similarly assigned to one or more residential units to provide on-unit recreational services. They attend community meetings and various other clinical meetings with clinical staff to plan and coordinate services for clients.
    d. Treatment psychologists commonly attend psychiatry appointments with clients on their caseload to improve interdepartmental communication and enhance client care.

Group Treatment

Strengths

1. Core groups have a clear structure that treatment staff followed in all groups observed. Similarly, staff that led psychoeducation groups followed the curriculum for each group.

2. The size of treatment and psychoeducation groups was appropriate, which was between 5 and 9 clients per group.

3. Treatment staff allocated a reasonable amount of relatively brief time to individual group members' "check-ins," which allowed adequate group time for clients to present homework assignments and address other issues. This is an improvement over group practices that were observed in some previous reviews during which group check-ins sometimes took an inordinate amount of time.

4. Clients typically focused their time in group on relevant issues. For example, clients regularly referenced their treatment plans and matrix factors when discussing current issues and presenting homework assignments in groups. As well, treatment staff regularly link what clients presented in groups with each client's treatment plans and matrix factors.

5. In general clients demonstrated connection to other group members, the clinician, and the group as whole.

6. Clinicians supported the development of safe and supportive positive group cultures.

7. Groups showed collaborative engagement in the therapeutic work, evidenced by clients providing feedback, accepting feedback, and relating other client's experiences to their own.

8. Clients in many groups were able to manage potential negative relationship factors demonstrated by communicating the importance of how feedback is given and how certain interactions impact their interpersonal relationship. As a result, there was good interaction and engagement, which resulted in good cohesion.

9. Client to client interaction predominated the majority of the group time.

10. Treatment staff reported valuing the regular clinical supervision they received regarding facilitating groups. Treatment staff appeared to be comfortable and competent facilitating groups, and they reported good job satisfaction with respect to facilitating groups.

Areas for Further Development Regarding Cohesion and Collaboration and/or Group Treatment

Staffing levels throughout the organization have been negatively impacted by budget pressures, which has impacted services, such as, in the following areas.

1. Lack of funding for some security and operations staff positions has required increased use of staff overtime. This has resulted in increased stress and decreased morale among security and operations staff. Some staff expressed concerns that current staffing levels could affect staff safety in dealing with clients prone to acting out violently towards other clients and staff.

2. Due to staffing levels, security and operations staff have fewer opportunities than in recent years to work collaboratively with clinical and other staff to plan and coordinate services for clients.

3. As a result of decreased clinical staffing, beginning in January 2019, clients will be offered only one versus two psychoeducation groups per treatment semester. Consequently, available scheduled weekly treatment hours per client will reduce to 7.5 hours from 9.0 hours. Further reduction in treatment hours could result in the program providing a lower treatment dosage than is considered appropriate and in line with what other sex offender civil commitment programs provide.

4. Decreased staffing levels in the recreation and education departments has resulted in a decrease of services in these areas.

5. Budget pressures have impacted some departments more than others, and this has created some tensions between departments, especially adding to an already existing sense of inequity between operations and clinical staff.

6. The Moose Lake facility has limited usable client bed space. Three units have been closed, and available bed space on the other units is located primarily on high security units for clients who have specialized needs, such as in the areas of acute or other serious mental health and behavior management problems. The program has made strides in recent years in using these high security beds to help clients stabilize and move back to other lower security living units as soon as possible. This approach follows best practices in client management and treatment for this population.

7. The lack of bed space creates tensions for clients and staff. Movement of one client for security or other necessary reasons, for example, often results in a domino effect in which several other clients need to be moved.

8. Several operations and security staff expressed concerns about inequity about job expectations and levels of accountability among different job classifications. Almost every secure mental health facility has different expectations for example, between clinical staff versus security staff and medical staff versus nursing staff. Staff may not agree with the differences, but a clear and consistent message may help to promote acceptance. MSOP administration should consider providing a general communication about the role and expectations for different classifications and ensure that all staff are held accountable to meet job expectations.

9. Several staff at mid-level and below expressed a desire for improved communication related to changes in polices, the reason for changes, and how changes impact individuals' work.

10. MSOP has begun to examine the type, frequency, and content of meetings to identify changes that may

improve communication for the current organizational structure and current workflow and reduce staff time spent in meetings. We support this quality improvement initiative.

11. There is notable variability in the frequency that clinical supervisors observe treatment groups led by their supervisees. We encourage the program to set clear expectations for clinical supervisors about how often they should observe groups. Additionally, we recommend that the program consider using a structured group observation form to guide supervisors' feedback to facilitators and to enhance fidelity to the treatment model.

We support the programs' ongoing quality improvement efforts to continue to review treatment task and assignments to ensure that they match the responsivity needs of clients, such as using language at lower grade levels and making treatment concepts as simple as possible.