Options for Managing the Growth and Cost of the Minnesota Sex Offender Program: Facility Study

Minnesota Sex Offender Program

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Options for Managing the Growth and Cost of the Minnesota Sex Offender Program: Facility Study

Report to the 2011 Minnesota Legislature

Minnesota Sex Offender Program, Minnesota Department of Human Services

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EXECUTIVE SUMMARY

Throughout Minnesota, managing sexual offenders and combating sexual violence is a complex issue with a wide scope and multi-agency approach. For years, Minnesota has been a leader on many fronts in this area from specialized caseloads for supervision agents, to the development of one of the first actuarial risk tools in the field (MNSOST-R). The Minnesota Legislature has requested several studies related to sexual violence and sexual offenders in the past 15 years which is indicative of its commitment to continue to evaluate and strengthen current practice and to develop strategies consistent with advancements in the field. Many recommendations from these reports have been implemented and have resulted in an improved system.

Minnesota is one of 20 states that enacted civil commitment statutes to indeterminately detain individuals for treatment to address their sexual dangerousness and as part of a broader strategy to manage the risks presented across the continuum of sexual offenders. The civil commitment program is expensive to maintain and the program continues to expand because more sexual offenders are entering than are being released. The cost and growth of the Minnesota Sex Offender Program (MSOP) continues to be an area of concern particularly given the current economic issues facing the state. Public safety cannot be compromised yet the growth of this program creates a strain on the state budget as the per diem for MSOP clients is $328 and projections indicate an expected annual growth of at least 50 additional clients. To address future growth and cost, the 2010 Legislature included a subdivision in the capital investment bonding bill requiring the commissioner of the Department of Human Services (DHS) to submit a report to the Legislature by January 15, 2011.

The commissioner tasked MSOP with the completion of this study. MSOP then convened four topical teams to provide analysis and recommendations for sex offender treatment, the civil commitment process, sexual abuse perpetration prevention, and bed space options for MSOP clients. These other facets of this issue were incorporated in this study to paint a complete picture of the growth of Minnesota's civil commitment program for sexual offenders and its subsequent need for expansion. Developing options to manage the growth and decrease the cost of MSOP was the charge for each topical team as they researched and provided analysis of their topic.

The treatment topical team found treatment systems in Minnesota have the potential to further reduce the need for civil commitments and to help support the release of some civilly committed individuals if they have made sufficient progress to warrant any court ordered release to society from MSOP. This results in an increased reliance on community-based treatment to manage higher risk sexual offenders. To make this shift responsibly, Minnesota should work to strengthen its community-based treatment options in several ways. These changes will require additional resources but it is likely that these additional costs will be more than offset through reductions in expected future MSOP operating costs and capital costs associated with program expansions.

The team that reviewed the current civil commitment process concluded these programs for sexual offenders are an expensive yet necessary tool in an effective, comprehensive statewide management strategy. The challenge for the State of Minnesota is to utilize MSOP efficiently while maintaining public safety in a fiscally responsible manner. Opportunities exist to impact the future cost and growth of MSOP by making modifications and revisions in the current process of civil commitment. Evaluating the application of commitment criteria in the referral process and considering options to indeterminate commitment would impact the number of new clients admitted to MSOP. Enhancing coordinated

community-based resources would increase the ability to manage this challenging population at a decreased cost. Once modifications and new policies are in place, an ongoing evaluation of the statewide management system for sex offenders would assist in maintaining efficiency and better ensure public safety.

Managing the growth and decreasing the cost of MSOP could be most effectively achieved if sexual abuse was prevented before someone perpetrated sexual harm. Prevention of sexual abuse perpetration was included in this study and report to illuminate the importance of preventing the creation of civilly committed sex offenders as well as preventing recidivism once MSOP clients are reintegrated into the community. By investing in a population-based public health approach to sexual violence prevention, Minnesota will be investing in long-term cost-savings for the state. A complex web of social norms, environmental factors, peer influence and individual decision-making that precedes an act of sexual violence. Ample opportunities for intervention and prevention exist.

After reviewing several options for renovation and expansion, the bed space options topical team concluded that both a short-term and a long-term solution are needed to address the projected growth of MSOP. In the short-term, MSOP should work with the Minnesota Security Hospital to move clients out of the Shantz building on the St. Peter campus. This allows MSOP to request asset preservation funds from the Legislature to complete the infrastructure renovations of the Shantz building. This will increase the capacity of MSOP by 55 additional beds, which will accommodate MSOP's bed space needs for one more year. This timing allows MSOP to review next year's projections and develop a bonding request for the 2012-2013 legislative sessions. The low operating costs of this recommendation will assist MSOP in lowering the overall per diem.

The long-term solution is the lowest on-going operating cost per client in adding a 400 bed living unit within the original design of the MSOP Moose Lake facility. This allows MSOP to take advantage of existing support infrastructure, security perimeter and administrative staff. The MSOP Moose Lake facility expansion also allows for building only 200 or 100 beds. The 200 bed addition would include adding only two of the five housing wings. The 100 bed option only builds one of the wings. These options will still require building the additional support infrastructure, but require less bonding dollars in the near term and still allow for the additional expansion of the other wings.

Minnesota would do well to continue to strengthen its multi-faceted, multi-agency approach to the issue of sex offender management and also, in preventing sexual violence. In moving forward, Minnesota should create and fund an on-going entity to coordinate, assess and improve statewide responses to sex offender management as well as to identify new and emerging issues. As this report demonstrates, the issue of sexual violence is exceedingly complex and thus requires an approach equal in its complexity including prevention, intervention and response.

It should be noted that the Office of Legislative Auditor (OLA) is in the process of conducting a program evaluation of MSOP. The OLA report to the Legislature will likely address some of these areas in further detail as well as provide suggestions and or recommendations for future direction.

INTRODUCTION

Background

This report was mandated by the 2010 capital investment bill along with its allocation of $47.5 million "to complete design for and to construct, furnish, and equip phase two of the Minnesota sex offender treatment program at Moose Lake."[1] These monies were requested to ensure the Minnesota Sex Offender Program (MSOP) would have sufficient space and would not exceed capacity. During discussion and debate at the Legislature regarding this allocation, questions emerged focusing on the feasibility of continued expansion of MSOP. Sex offender treatment as well as the prevention of sexual violence was discussed as measures to slow the need and urgency to build bed spaces for civilly committed sex offenders, particularly given the cost of treating MSOP clients and the current state budget deficit. A subdivision was included in the bill requiring the commissioner of the Department of Human Services (DHS) to submit a report to the Legislature by January 15, 2011.[2]

Methodology

The commissioner of Human Services tasked MSOP with the completion of this study. MSOP convened four topical teams to provide analysis and recommendations for sex offender treatment, the civil commitment process, sexual abuse perpetration prevention, and bed space options for MSOP clients. These other facets of this issue were incorporated in this study to paint a complete picture of the growth of Minnesota's civil commitment program for sexual offenders and its subsequent need for expansion.

Each team reviewed multiple sources of information including past legislative reports and relevant statistics and documents. Team chairs worked in consultation with various stakeholders and other state departments including the Departments of Corrections and Administration. Each team provided a summary of the current status as well as recommendations for moving forward to manage the growth of MSOP and to prevent sexual abuse. A summary of recommendations follows.

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[1]Minn. Stat. § 189, subd. 5 (2010)

[2]Minn. Stat. §189, section 18, subd. 6 (2010): Sex Offender Treatment Center; Facility Study
The commissioner of human services, in consultation with the commissioners of corrections and administration, shall study the potential for using existing vacant or underused state facilities, including regional treatment centers, for the sex offender treatment program or for other programs or services administered by the Department of Human Services. The study must analyze the feasibility, time required, and cost of making the building and infrastructure changes necessary for the program. The study must also examine the current civil commitment policies of the state, sex offender treatment, and possible legislation to change determinate sentencing for sex offenders. The study must include a review of how other states use civil commitment for sex offenders. The commissioner shall submit a report on the study, with specific recommendations, to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over capital investment, human services policy and finance, and public safety policy and finance by January 15, 2011.

TREATMENT OF SEXUAL OFFENDERS

Treatment Topical Team Charge and Participants

Over the past several decades, the State of Minnesota has made significant investments in a number of interrelated systems designed to manage the risks posed to the public by sexual offenders. These systems include a continuum of treatment services across Minnesota's communities, as well as prison programs and a program for civilly committed sexual offenders. In accordance with best practices in the field, sex offender treatment has been carefully paired in Minnesota with specialized community supervision resources and this combination has been shown to be very effective in reducing new sexual offenses by convicted sexual offenders (Duwe & Goldman, 2009).

The question posed to this topical team relates to the challenges presented by the growing population in Minnesota's civil commitment program. A number of factors related to the growth of MSOP's population have been reviewed for this study. In this section, focus is on Minnesota's existing treatment systems and resources as they relate to MSOP and make recommendations that serve to protect public safety while helping to manage the growth of the program in the years ahead. In drafting its section of this report, the team also reviewed recommendations from previous Minnesota legislative studies.

The team was chaired by Steve Allen, Behavioral Health Services Director with the Minnesota Department of Corrections (DOC). Team members included: Jannine Hebert, Executive Clinical Director, MSOP, DHS; Steve Sawyer, Licensed Clinical Social Worker, Sawyer, Solutions, LLC; Timothy Schrupp, Program and Policy Monitor, DOC; and Robert Manske, Analyst, DOC.

Section I: Overview of the Sex Offender Treatment Field

Sex Offender Assessment and Treatment

The goal of sexual offender treatment is to prevent sexual abuse. As the sex offender treatment field has gained an appreciation of the clinical complexity and range of risk this population presents, many different treatment strategies have been developed and, sometimes, borrowed from other disciplines in the effort to successfully meet this goal. In the early 1970's behavior modification was the standard of care in the field. Eventually, clinicians and researchers came to understand that modifying behavior alone did not result in sustained, long term change. In the 1970's and 80's it became common practice to address the intersection of thoughts as they related to behaviors: cognitive behavioral treatment. This brought into vogue the use of relapse prevention strategies, heavily borrowed from their success in addictions treatment. Recent advances in treatment design have focused on increasing internal motivation by further individualizing treatment based on more nuanced understandings of offending dynamics and then assisting offenders in developing the skills and internal investment in non-abusive lifestyles. It readily became apparent that not all sexual offenders are at equal risk to reoffend, nor do they present with the same treatment needs. As clinicians continued to explore treatment strategies, researchers concentrated on developing risk assessment tools.

Determining re-offense risk with sexual offenders was initially based on professional judgment. Clinicians relied on their own professional experiences to render opinions. Actuarial risk assessment tools were developed beginning in the 1990's, based on retrospective studies of sexual offenders who had reoffended. These assessments introduced static (unchangeable) risk factors to the field. With these tools, clinicians were able to more accurately differentiate and classify offenders based on their potential for re-offense. While actuarial tools changed the landscape of sex offender treatment and management, they did not account for personal change or the impact of successful treatment. In the 2000's researchers made significant advances in understanding the role of dynamic (changeable) risk factors in predicting risk. Robust research identified "criminogenic needs" which are problem areas associated with sexual re-offense or dynamic factors that become targets for treatment and opportunities to reduce risk through treatment[3].

While the field of sex offender treatment has undergone some remarkable developments in a relatively brief period of time, one of the most important of these has been in differentiating sexual offenders by risk and by treatment needs. A more sophisticated understanding of sex offending dynamics, coupled with improvements in treatment approaches has allowed states to develop a continuum of intervention approaches with various levels of intensity that can be matched to an offender's offense dynamics, assessed level of pathology and risk. Civilly committed sexual offenders are those deemed to pose the greatest risk to the community. Therefore, civil commitment programs have been designed in accordance with the risk/needs principles (see below) to address the highest levels of risk specific issues through a comprehensive array of approaches, including highly specialized intervention strategies, the longest treatment durations, extensive pre-release preparations and intensive post-release supervision.

The term "sex offender" is a legal term that is based on behavior; it does not describe a clinical picture, determine a mental health diagnosis, or identify a needed course of treatment. Legal labels or commitment criteria do not determine an effective treatment plan. One of the many challenges for treatment providers is to create an individualized treatment plan that is consistent with risk-informed research. Treatment clinicians must carve out individual treatment targets within the parameters of research in the field. Generally accepted treatment of sexual offenders utilizes techniques that facilitate understanding and manage thoughts, emotions, and behaviors. Treatment typically utilizes both individual and group therapy. Assessments are conducted using objective measures such as psychological testing, psycho-physiological measures such as polygraph, or plethysmography[4]. Actuarial measures such as the Static 99R[5] or the MnSOST-R[6] are used to assess risk to reoffend. Increasingly, dynamic risk instruments are also being utilized by the field to complement actuarial instruments.

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[3] While the field has made significant advancements in risk assessment, there is no single tool or combination of assessment tools that can predict future human behavior with complete accuracy.

[4] Phallometric testing uses a measure of penile erection in response to a variety or stimuli to determine an individual's pattern of sexual arousal. They stimuli used typically include males and females, adults and children, and may include aspects of coercion, use of force, or noncontact sexual behavior. The stimuli may be photos, audio files, or a combination of the two (Marshall & Fernandez, 2003).

[5] The Static-99 was developed to combine two risk assessment tools (i.e., Rapid Risk Assessment of Sex Offender Recidivism; RRASOR and Structured Anchored Clinical Judgment-minimum; SACJ-Min) (Hanson & Thornton, 2000). This actuarial risk assessment scale was designed for use with adult male sexual offenders to predict sexual and violent recidivism. It is also the most widely researched tool in this area (Helmus, Hanson, and Thornton, 2009). The Static – 99R adjusts the impact of age in the risk rating as outlined in the Static- 99R Evaluators' Workbook (Phenix, Helmus & Hanson, 2009).

The Risk, Needs, and Responsivity Principle

Offender management across all offender types in the last decade has been heavily influenced by research on the so called "risk/needs" principles (Andrews & Bonta, 2003). The risk principle states that the intensity of management resources (including treatment) should be matched to the level of risk posed by individual offenders, with the most intensive levels of intervention reserved for higher risk offenders, and lower intensity or no intervention applied to lower risk offenders. Level of risk is typically established through the assessment of static and dynamic factors.

The needs principle states that the most effective interventions are those that target offenders' criminogenic needs or dynamic risk factors. These dynamic factors are those that are associated with risk for re-offending but, unlike the static factors, can be changed through intervention, and when changed, are associated with changes in recidivism risk. Dynamic risk factors can also be conceptualized as psychological vulnerabilities or mechanisms that, in conjunction with situational triggers, significantly increase risk for reoffending (Ward & Beech, 2004). The responsivity principle states that interventions should be delivered in a manner consistent with offenders' learning styles, abilities, and personal circumstances.

Civil Commitment Programs

Treatment has come to play an important role in the management of sexual offenders in general but even more so with those offenders at the highest end of the risk continuum. Minnesota has developed a civil commitment option for sexual offenders as part of a comprehensive management approach. Sexually Violent Person (SVP) is a term frequently used to describe those sexual offenders who are considered the most dangerous and present with particular challenges for the courts. Most states have the ability to civilly commit individuals for mental illness or other conditions that significantly impair their ability to live safely in the community. These provisions for mentally ill individuals, particularly for those who are categorized as mentally ill and dangerous to the public, have typically served as the legal foundation to create options to civilly commit sexual offenders deemed too dangerous to be released after having served their correctional time. Currently, 20 state SVP programs are operational in the United States. The Federal Bureau of Prisons also has a civil commitment program, the authority for which was recently upheld by the Supreme Court. Currently, there are over 4000 civilly committed sexual offenders across the country (see Appendix B).

Public outrage at especially heinous sexual offenses has often played a role in the establishment or redesign of SVP programs and these local tragedies have also influenced how individual programs have developed in important ways. Due in part to these dynamics, SVP programs vary across the country in significant ways. For example, while most programs are residential in design and focus on the treatment of adult males, Pennsylvania only commits juveniles and the Texas program is designed as an outpatient program. The treatment approaches within these SVP programs, nonetheless, are generally consistent and reflect the current state of research (i.e. cognitive behavioral, relapse prevention, arousal

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[6] This scale emerged from efforts made in response to a 1991 Minnesota Department of Corrections special report calling for a more formal and uniform process to identify high risk sexual offenders (Epperson, Kaul, Huot, Goldman, & Alexander, 2003).

management). Interventions are typically delivered utilizing group therapy and consist of both process and psycho educational treatment.[7]

The growth of Minnesota's civil commitment program over the past two decades is not unique. Simply put, civil commitment programs for sexual offenders have been growing because there are more offenders entering them than are being released.

Research: Treatment Outcomes and Recidivism

Recidivism of sexual offenders, more specifically, the effectiveness of sex offender treatment has received considerable attention over the past two decades in the professional literature. The debate about treatment impact was deepened with advanced science and rigor after a study by Furby, Weinrott, and Blackshaw in 1989 that reviewed the available outcome studies at the time and found that the existing literature did not support the conclusion that treatment had a significant impact on recidivism. While there remains some level of public perception that treatment does not work and all sexual offenders reoffend, studies completed in the past decade have shown a more optimistic view. The change in research findings is likely due to both improvements in treatment along with more consistently rigorous outcome studies.

Since 1989, numerous small and large scale national and international studies examining the impact of treatment have been completed. Large national and international studies have consistently shown sexual offenders recidivating at lower rates compared to non-sexual offenders. Two large studies found sexual re-offense rates from 5.3% (Langan, Schmitt, & Durose, 2003, n = 9,691) to 13.4% (Hanson & Bussière, 1998, n = 23,393). By aggregating studies, meta-analyses have been increasingly used as a method to assess impact across a large number of offenders and studies, decreasing the natural variability across individual studies while increasing the robustness of the findings. One of the most respected meta-analyses (Hanson, et al, 2002) found that treated groups reoffended at a rate of 12.3% compared to untreated groups with a 16.8% re-offense rate (total n= 9,454). Lösel and Schmucker (2005) found that, in general, studies have shown 5-10% lower recidivism for those who complete sexual offender treatment. In their meta-analysis (total n = 22,181), those who completed treatment had recidivism rates of 11.1% compared to a recidivism rate of 17.5% for those who did not complete treatment.

Minnesota-Specific Studies

A number of published studies have been conducted in Minnesota that have contributed to the field and shed additional light on sex offending dynamics in this state. In a recently published study, Duwe and Goldman (2010) followed a cohort of over 2000 offenders over an average nine year follow up period and found a recidivism rate of 13.4% for those who completed or participated in prison-based treatment compared to a 19.5% sexual recidivism rate for those who did not complete treatment. In a study of outpatient community-based treatment, Sawyer and Pettman (2006) followed offenders over a period of five years post-treatment and found sexual recidivism rates of 2.6% for those who completed outpatient treatment compared to a 4.4% sexual re-offense rates for those who did not. Swinborne Romine, Dwyer, Mathiowetz, and Thomas (2008) found a 13.6% sexual recidivism rate in a community sample of adult offenders who were seen in an outpatient community program. Thus, treatment of sexual

[7] See Appendix B for more comprehensive overview of the existing SVP programs.

offenders utilizing cognitive behavioral techniques has been shown to reduce the rate of sexual recidivism when compared to offenders who did not receive treatment.

Section II: Sex Offender Treatment Resources in Minnesota

Treatment Continuum in Minnesota

Treatment for adult sexual offenders in Minnesota occurs in a variety of practice settings in the community and in correctional and human services institutions. Treatment services are provided in settings ranging from no physical restrictions (small private practice offices and community-based treatment programs) to high security state facilities (prison-based and civil commitment program). Treatment takes place in the following settings (see Appendix A for geographic representation):

- *Community outpatient private practice programs* (COPP) are typically developed individualized programs. Their overall clientele base is often smaller and many do not have enough clients for specialized group interventions;
- *Community outpatient structured programs* (COSP) operate in private clinics, private not-for profit-agencies, or community mental health centers. Several larger programs exist in the Minneapolis/St. Paul metro area and throughout the state;
- *Community inpatient residential programs* (CIRP) are operated as non-profit agencies. Minnesota has one such program located in Minneapolis;
- *Prison-based residential sex offender treatment programs* (SOTP) for adult male offenders currently operated in two Minnesota Correctional Facilities (Rush City – 60 beds and Lino Lakes – 205 beds). Additionally, DHS and DOC operate a 50 bed collaborative program in DOC's Moose Lake facility (MSOP-DOC). The DOC operates a 26 bed residential program for juvenile males within the Red Wing correctional facility and an eight bed outpatient sex offender program for adult women in the Shakopee women's correctional facility.
- *Civil commitment treatment program* through the DHS' Minnesota Sex Offender Program (MSOP) in St. Peter (capacity of 197) and Moose Lake (capacity of 550).

Costs vary widely for these various options as do the funding sources. Prison-based and civil commitment programs are funded through state agency budgets. Community treatment and other interventions may be funded through a variety of funding sources, including offender co-payments, insurance payments, county funding, state grant funding. The DOC provides grant funding to support community treatment programs through a Request for Proposal (RFP) process.

Table 1.1. *Costs of treatment program based on estimates from the DOC and the DHS*

Approximate Cost	***Options***
$120,000	One year in MSOP
$31,000	One year in state prison with treatment[8]
$5,000 – $15,000	One year of intensive supervision and outpatient treatment
$3,500 *($150 - $600 per month, $1800 - $7200 per year)*	One year of outpatient treatment
$7,000	One year on GPS monitoring
$2,200	One year on electronic home monitoring

[8] The DOC number includes the cost of health care, including sex offender treatment.

Community-Based Sex Offender Treatment

Minnesota has a range of community-based sex offender treatment services which are situated in the Minneapolis/St. Paul metropolitan area and in greater Minnesota (see Appendix A). A significant portion of these treatment services are subsidized through state grants administered by the DOC which maintains data on these grant-funded programs and portions of that data are provided in this report. The DOC also requires grant-funded programs to adhere to treatment guidelines[9] and these programs receive ongoing inspections to ensure compliance. Since there is no current mechanism for data collection for non-DOC funded providers of sex offender treatment, no comprehensive review of the Minnesota's community programs was possible for this report. Also, no current centralized mechanism for evaluating the quality of treatment across all community outpatient treatment resources exists.

State Funded Services

State support for community sex offender treatment is authorized under Minnesota Statute[10] and provides funding for both juvenile and adult sex offenders on supervised release, conditional release, or probation. In FY09, programs that received funding for sex offender treatment served 1704 offenders including 1,574 adults (92%) and 130 juveniles (8%) in 83 counties across the state. Funds awarded amounted to $2,400,687 and provided to a total of 12 community agencies or programs and 41 different program sites. The funds were distributed to programs within counties of all three probationary systems in Minnesota.[11]

Sex offenders eligible for funding under these grants include:

1. Juvenile offenders who had been found delinquent or received a stay of adjudication, for whom the juvenile court has ordered treatment;
2. Adult offenders for whom treatment is required by the court as a condition of probation;
3. Adult offenders released from a Minnesota Correctional Facility for whom outpatient programming and/or aftercare are required for conditional release under Minnesota Statutes section 609.1352 or as a condition of supervised release;
4. Adults and juveniles committed to the custody of the commissioner of corrections.

The Department of Human Services also contracts with community-based treatment providers to provide services for the MSOP clients in the later stages of treatment – called Community Preparation Services (CPS) – through a separate funding mechanism.

Services Provided

Sex offenders in DOC grant-funded programs participate in treatment as a condition of their probation or supervised release and are required to pay a portion of the treatment expense. Polygraph

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[9] These treatment guidelines were developed in response to the 2005 Office of the Legislative Auditor report on community supervision of sexual offenders and subsequently published in 2007 but never implemented as a state-wide requirement.
[10] 241.67, Subd. 1, Subd. 3(b), and Subd. 8 and statue 242.195, Subd. 1.
[11] Minnesota Association of Community Corrections Act Counties, Minnesota Association of County Probation Officers and the DOC.

examinations are also a component of services provided, with funds made available through the grants to those programs that administer such testing. Most offenders who are provided treatment under this funding mechanism are classified as Level 1 and Level 2 under the Community Notification Risk Level system.[12]

In addition to the 12 community agencies and programs that currently receive DOC grant funds as a portion of their revenue, there are approximately 11 other agencies, private practices, or programs that serve a variety of sexual offenders, including the mentally ill, developmentally delayed, and other special needs individuals. Funding for these programs is typically provided through offender co-payments, county human services funds, insurance, or other sources. Community-based programs are the least restrictive settings and are where most offenders are treated. One thousand seven hundred offenders treated in FY09 versus approximately 450 in DOC institutions.

Treatment in the community typically consists of group therapy and/or individual therapy for one to three hours per week. Some programs include family therapy, educational sessions, and therapy for the spouses or partners of the offenders, or other related services. Most programs are open-ended, meaning a client stays in treatment until the program expectations are completed (versus a time-limited program length). Some programs for misdemeanor offenses are time-limited based on the length of probation (for example, one year probation for single acts of exposing or window peeping). Most programs charge some level of offender copayment for services, typically based on ability to pay.

Sex Offender Treatment in Minnesota Prisons

The Minnesota Department of Corrections has been providing sex offender treatment to incarcerated adult men since 1978. Currently, Minnesota has four programs offering residential sex offender and/or chemical dependency treatment to adult male sexual offenders. The MSOP-DOC program located at MCF-Moose Lake is one of these programs and represents collaboration between DHS and DOC (described in the next section). As noted above, the DOC maintains a program for juvenile sexual offenders at MCF-Red Wing and a program for adult women at MCF-Shakopee.

SEX OFFENDER TREATMENT PROGRAM (SOTP) AT MCF-LINO LAKES

Capacity: 208 adult males

The MCF-LL SOTP opened in 1978, and offers long-term residential sex offender (SO) and chemical dependency (CD) treatment in a Medium custody facility. Treatment length is typically 20 months for those who are enrolled in SO treatment only, and 30 months for offenders enrolled in CD and SO programming.

SEX OFFENDER TREATMENT PROGRAM (SOTP) AT MCF-RUSH CITY

Capacity: 60 adult males

The MCF-RC SOTP opened in 2006, and offers long-term residential SO treatment in a Close custody facility. Treatment length is typically 20 months for those who are enrolled in SO programming.

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[12] Level 1: 271, Level 2: 160, Level 3: 21

RESHAPE PROGRAM AT MCF-ST. CLOUD

Capacity: 32 adult males

The Reshape Program offers residential chemical dependency treatment to adult male sex offenders. Many of these offenders will enter either the MCF-LL or MCF-RC SOTP later in their incarceration if their sentence is long enough or will be referred to a community-based sex offender program on release.

Treatment Overview

Approximately 1800 adult male sex offenders are incarcerated in DOC facilities with a directive to treatment. Due to resource limitations, sex offender treatment can only be offered to a limited number of these offenders prior to their release back to their communities (approximately 30%[13]). The DOC prioritizes treatment to those sex offenders who are assessed as moderate to high risk to reoffend. Sex offenders who do not receive treatment before being released to the community are typically required to complete outpatient programming as a condition of supervised release.

Treatment begins with a complete psychosexual assessment, which includes psychological testing, a detailed review of the offender's history, and a thorough clinical interview. The assessment identifies the offender's criminogenic needs. Examples of these need areas include sexual deviancy, antisocial attitudes and beliefs, relationship problems, and problems with self-regulation. The assessment leads to development of an individual treatment plan that identifies treatment interventions that are designed specifically to address these deficits for the offender. Interventions include group and individual therapy, psycho-educational classes, and community meetings. Offenders are housed in living units separate from the general prison population and are expected to demonstrate prosocial behavior within that environment, called a therapeutic community. Therapy and security staffs work closely together to monitor offender behavior within the living unit. Offenders are offered transitional programming as they near their release date, to assist the offender in securing appropriate employment and residence, and to provide for follow-up treatment or aftercare upon release.

Residential sex offender treatment programs in the DOC are required by statute to meet certification standards under Minnesota Rule 2965.[14] These standards contain requirements for programming hours, staff education, training and clinical supervision, as well as group and staffing ratios. Programs are required to have a written theory-based treatment protocol and to demonstrate that they apply this to the assessment, treatment, and therapeutic milieu in each program. Programs are audited for compliance to these standards on a bi-annual basis.

The MSOP-DOC Site Program

In 2000, the DOC consolidated its existing sex offender treatment programs into the expanded SOTP program at MCF-Lino Lakes, including the DOC program previously housed at MCF- Moose Lake. In 1993, the Minnesota Legislature approved $20 million for a 100 bed Department of Human

[13] Recent improvements in DOC analysis methods have found somewhat higher percentages of sex offenders being treated prior to release than have reported in the past.
[14] The juvenile program at MCF-Red Wing is regulated under Minnesota Rule 2955.

Services facility in Moose Lake, Minnesota for the purpose of providing sex offender treatment for those civilly committed as either Sexually Dangerous or Sexual Psychopathic Personality.

A DHS proposal led to collaboration between the Departments of Human Services and Corrections to enhance the DOC's treatment capabilities with offenders likely to be civilly committed. The 50 bed MSOP-DOC site program that emerged from this collaboration and was placed at MCF-Moose Lake and staffed with DHS treatment providers in order to closely replicate the treatment design these offenders would receive if civilly committed. Treatment during the offender's prison stay had the advantage of allowing for significantly reduced overall cost when compared to civil commitment and the potential to either decrease the need for civil commitments or reduce their duration in treatment once the committed offenders entered the MSOP program.

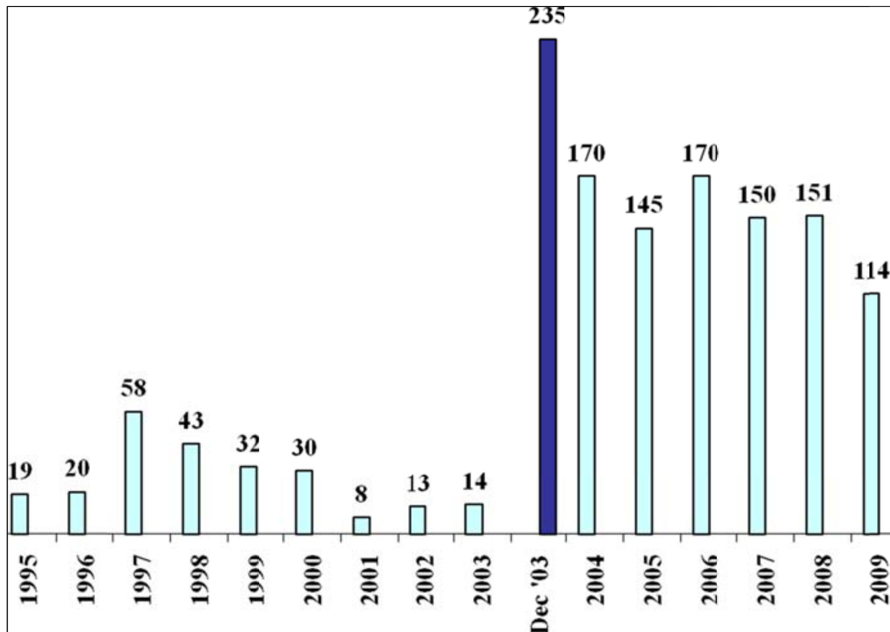
The MSOP-DOC site program is housed in a 50-bed living unit and paired alongside the DOC's 60-bed Paradigm chemical dependency program. A portion of the chemical dependency treatment beds are allocated for sexual offenders. Sex offenders who have chemical dependency treatment needs receive specially designed interventions in the Paradigm program at MCF-Moose Lake prior to entry into the MSOP-DOC site program. The MSOP-DOC site program is also regulated under Minnesota Rule 2965.

Minnesota Sex Offender Program (MSOP)

In 1939 Minnesota enacted the Psychopathic Personality (PP) law providing the state with the mechanism to civilly commit individuals with sex offense behaviors who met the statutory criteria. In 1973 the Minnesota Security Hospital developed the first comprehensive treatment program for these civilly committed sexual offenders called BEAD (Behavioral Emotional and Attitudinal Development) and in 1975, ITPSA (Intensified Treatment Program for Sexually Aggressives) was developed. By 1992 the use of the PP commitment had increased and the program in St. Peter continued to expand. Due to the need for additional space, in 1995 the facility at Moose Lake opened with an additional 100 beds. MSOP continued to grow and, in 2007, having reached capacity in Moose Lake, clients were temporarily moved to two buildings within the nearby MCF-Moose Lake perimeter until construction was completed in July of 2009. MSOP is currently housed at two facilities. The St. Peter site houses approximately 150 individuals and provides assessment and intake services as well as the transition preparation portions of the program. The Moose Lake facility has approximately 450 individuals and provides the primary treatment components.

Civil commitments increased significantly beginning in 2003 due to an increase of referrals following a high profile sex offense and stayed at a higher than historical average level afterwards. However, the past year has seen a decrease in both referrals and commitments.

Figure 1.1. *Civil commitments by year, 1995 – 2009*



Program Philosophy

The Minnesota Sex Offender Program draws on several contemporary treatment models in its programming (Levenson & Prescott, 2007), including cognitive-behavioral therapy, group psychotherapy, relapse prevention (Hanson et al, 2002), risk/needs/responsivity (Hanson, Bourgon, Helmus, & Hodgson, 2009) and stages of change literature (Prochaska, 1999; Prochaska, DiClemente, & Norcross, 1992), with additional philosophical influences from the Good Lives model (Yates, 2009). Treatment is guided by an individualized treatment plan that defines measurable goals throughout treatment in MSOP. It is the charge of MSOP to make treatment available to all clients who are civilly committed. At the same time, neither treatment nor personal change can be forced on individuals in the program. While clients are encouraged to participate in treatment, they have the right to refuse or discontinue participation at any time. Currently MSOP has an 80% participation rate which is consistent with other civil commitment programs across the country. Clients initially address attitudes and behaviors that can interfere with progress in treatment in preparation for the next phase where they focus on their patterns of abuse and identifying and resolving the underlying issues in their offenses. Clients in the later stages of treatment focus on maintaining the changes they have made and prepare for successful reintegration into the community.

Treatment Program

MSOP's treatment program uses a three-phase system similar in structure to those used in other civil commitment programs in the United States. Clients active in treatment participate in process and psycho-educational groups. Individual treatment plans also incorporate rehabilitative services and goals. These include therapeutic recreation, vocational training and education.

Three phases of treatment:

Phase I focuses primarily on clients' ability to maintain behavioral control and consistently conform to the rules of the program. Clients work to develop skills in problem-solving, understanding and reducing therapy-interfering behaviors (or barriers to change), and begin to develop an understanding of how thought processes affect behavior.

Phase II focuses primarily on securing an agreed upon history of the client's offending behavior and the factors that contributed to it. Clients are expected to identify and develop resolution of the issues underlying their offense behaviors.

Phase III focuses on the application and internalization of the treatment process. Skill acquisition and rehearsal is targeted. Clients are expected to demonstrate meaningful change and consistent utilization of effective pro-social coping skills while managing their risk for re-offense.

Just as the courts determine who is sent to MSOP, the courts determine the transfer and release. Civil committees have the right to petition every 6 months for provisional or full discharge or placement in a less secure setting. These petitions are heard by a 3-person Special Review Board (SRB) that makes a recommendation to a 3-judge Supreme Court of Appeals Panel (SCAP). MSOP clinical staff prepares risk assessments as well as treatment progress reports for the SRB and SCAP. Clients' petitions may or may not be supported by the treatment team. The courts make the final determination on release regardless of the position of the DHS Commissioner or the MSOP clinical team.

Matrix Factors

MSOP uses a matrix of treatment expectations that are linked with criminogenic needs/dynamic risk factors and that provide the basis for treatment progress (see Appendix B for complete list). Clients are expected to demonstrate competencies in each area in order to progress to the next phase. Not every client will need to focus on each factor intensively. Each client comes with a unique range of treatment strengths and needs.

Programming Units

MSOP clients who choose to engage in treatment participate in a sexual offender assessment which sets the foundation for their individualized treatment plan. Clients are then placed in programming based on their clinical profile. The majority of MSOP clients receive treatment within Conventional Programming Units (CPU). MSOP provides sexual offender specific treatment to meet the needs of all clients.

Admissions (ADM): Clients newly admitted to MSOP and/or are going through the commitment proceedings. Clients are participating in assessments required by the court.

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

Behavior Therapy Unit (BTU): Clients who demonstrate behaviors that are disruptive to the general population and/or affect the safety of the facility (i.e. aggressive or assaultive behavior, threats, predatory

behaviors, etc.) are treated on this unit with the goal of mainstreaming once the conduct that undermines facility safety or interferes with treatment has been successfully addressed.

Corrective Thinking Unit (CTU): The CTU provides treatment to clients with high and very high levels of psychopathic traits.

Skill Building Unit (SBU): Clients with significant mental health needs and/or significant personality disorders that result in persistent emotional instability and/or potential self-harm reside in this unit.

Therapeutic Concepts Unit (TCU): Clients actively choosing not to participate in sexual offender specific programming are placed in this unit.

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 are in this unit.

Alternative Programming: These clients may have cognitive impairments, traumatic brain injuries and/or profound learning disabilities. Although motivated for treatment, it is unlikely that these clients would be successful in a conventional cognitive behavioral treatment program due to compromised executive functioning. Participants in this program all reside at the St. Peter campus.

Reintegration

Once clients have progressed to Phase III of treatment and have demonstrated meaningful change, they develop an individualized treatment plan directed at successful reintegration back into the community. Gradual deinstitutionalization becomes the primary focus of treatment and occurs at the St. Peter facility. While living in a secure treatment unit, clients gradually achieve levels of privileges that provide opportunities to apply treatment skills while continually managing their risk. Clients start with staff-escorted walks on campus, and progress to staff-escorted community outings. The final privilege attainment level is independent unescorted grounds privileges at the St. Peter MSOP site. All MSOP clients in St. Peter have Area Monitoring System ankle bracelets for supervision.

Clients petition to the SRB for placement in MSOP Community Preparation Services (CPS) which is located outside of the secure perimeter on the St. Peter campus. Recommendations from the SRB are forwarded to the SCAP who makes the final placement determination. Once a client has received the court approval he/she is moved to one of two buildings that comprise MSOP CPS. Clients continue to utilize attained privileges and adhere to a treatment plan that provides direction for ongoing reintegration. All CPS clients gradually increase their community interactions through attendance at Alcoholics Anonymous/Narcotics Anonymous groups, community-based sex offender treatment, as well as volunteer opportunities. Clients continue to participate in treatment in MSOP and maintain their on-campus vocational work assignments. Clients petition for provisional discharge through SRB and SCAP. It is anticipated that MSOP clients on provisional discharge will temporarily reside in a halfway house to assist in their transition before being placed in appropriate permanent housing.

Section III: Treatment and Civil Commitment in Minnesota

Because treatment is the underlying purpose and function of civil commitment programs and because treatment has been shown to be effective in reducing risk, it is worthwhile to evaluate whether or how treatment can also reduce the need for or duration of civil commitments, potentially slowing MSOP admissions or, conversely, helping to facilitate the "flow" of clients out of MSOP.

Given that treatment participation has the potential to reduce risk, it is reasonable to consider whether the provision of community or prison-based treatment does, or has the potential to, reduce civil commitments. An initial review created for this report found very high rates of prior treatment participation by Minnesota's civilly committed population. Almost 90% of the MSOP clients reviewed had had at least one sex offender treatment admission prior to their commitment. Almost 70% had entered two or more treatment programs and 20% had entered five or more.

While this data raises additional questions, it is reassuring that treatment has been provided to this high risk group of offenders. It suggests, in accordance with the risk/needs principle, that high risk offenders in Minnesota are being identified and placed in treatment programs. It is likely that many of the small subgroup who did not participate in a treatment program prior to their commitment either refused treatment or presented with categorical denial of their offenses (which is a common reason for a treatment program to not admit a client to a program).

The fact that treatment participation did not "prevent" civil commitment for these individuals, however, is relevant and worthy of additional discussion. While it is reasonable to expect some level of correlation between treatment participation and a reduced need for civil commitment, there are both clinical and non-clinical dynamics involved. The MSOP review found very high rates of prior treatment participation among its civilly committed population but the outcome of these treatment entries has yet to be reviewed. Treatment participation has a bi-directional effect on risk status, depending on outcome. Successful treatment participation, on the one hand, is associated with reduced risk while treatment failure is associated with elevated risk for reoffending. Thus, treatment participation can either significantly reduce *or* increase an individual's risk status. For the portion of those civilly committed individuals who participated in and failed treatment prior to their commitment, it is likely that the failure(s) played a role in their commitment as indicating an increased risk for offending.

Nonetheless, offenders who have successfully participated in treatment are still are civilly committed. Sufficient study of these cases has not been conducted; therefore, this team had little data on which to draw conclusions. However, a number of likely possibilities are:

- Some offenders recidivate or continue to engage in high risk conduct following successful participation in treatment. While not common, based on recidivism studies, it suggests the need for higher levels of supervision and more intense or sophisticated treatment interventions.
- Treatment and supervision are an extension of the assessment process. In some cases, an offender's conduct in treatment and on supervision increases their assessed risk.
- Successful treatment *reduces* risk but does not eliminate it. In some cases, the reductions achieved through treatment, when weighed against the case as a whole, remain insufficient to guarantee public safety; thus suggesting the need for a higher intensity treatment within a secure setting.

- Additional offender disclosures made during treatment are encouraged and expected. It may be that in commitment proceedings, however, the increased perception of risk associated with these disclosures offset, to some extent, the perceived reduction in risk achieved through the treatment process.

Insufficient data exists for this team to evaluate the relationship between treatment progress and either referrals to the county for civil commitment reviews or commitments, themselves. As part of the efforts in developing this report, the DOC reviewed all offenders incarcerated in Minnesota prisons that were subsequently referred to their counties for commitment review during the years 2004 to 2007 and then analyzed the final disposition of the commitment referrals.[15] This time period was selected because it may take several years for results of most commitment referrals to be determined and then that information provided to the DOC.

The analysis reviewed 567 offenders who had been referred for commitment review during the years 2004 through 2007. Approximately half of this cohort (47%) had participated in a prison-based treatment program prior to their release. Of those referred, nearly half were ultimately committed.[16] Further, commitment rates (ranging from 44-46%) were virtually identical for those who participated in treatment versus those who did not. Interestingly, successful participation in treatment was not associated with a significant reduction in commitment rates for this group. Forty-five percent of those who successfully participated in treatment were committed while 48% of those who were not successful in treatment were committed.

Why doesn't successful participation in prison treatment appear to have more of an impact on civil commitment decisions? In short insufficient information at this point does not allow for a determination, and ultimately answer is likely to include multiple elements.

First, risk assessments are partially based on actuarial scores. These tools are designed to address static factors. Static factors are not impacted by treatment completion or dynamic changes. Therefore an individual may enter treatment and successfully complete treatment without change to their risk score on actuarial tools. The field continues to advance in the area of defining and measuring dynamic risk factors. Thorough risk assessments should account for both dynamic as well as static risk factors. Unfortunately, the legal criteria for civil commitment emphasize the static factors and do not recognize or give credit for positive impact on dynamic factors that are often the case in successful treatment.

Second, the DOC review takes into account the outcome of cases *after* county referral but there was no available information regarding the effect of successful treatment participation on the referral process, itself. It is likely that successful treatment participation decreases the likelihood of cases being referred because of the known relationship between treatment and risk. This represents a real and expected reduction in commitments related to treatment participation that would not be apparent when reviewing the commitment results of those offenders who had been referred to the counties. We recommend further study in this area.

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[15] The information on Civil Commitment status is based on data provided to DOC from multiple sources as of August 31, 2010. Receipt of this information is inconsistent and thus may not be complete. Treatment result is based on the most recent treatment entry at either MSOP-DOC or an SOTP as of the date of the analysis which was September 9, 2010. It should also be noted that resolution of civil commitments may take several years. For this reason, we have provided information on the 2004-2007 cohorts. The status of a significant percentage of more recent cohorts is unresolved.

[16] 45% committed, 44% not committed, 11% remaining under review.

A third area deserving additional attention is how treatment participation is evaluated for the civil commitment process in Minnesota. Minnesota courts are expected to consider "the person's record with respect to sex therapy programs" as a component of the civil commitment process based on the so called Linehan factors (Kirwin, 2010). Nonetheless, further study may be warranted related to how successful treatment participation is assessed and presented by forensic evaluators and then "weighted"[17] by the courts in these commitment decisions. Without specific guidance, it may also be that this "weighting" of the effect of treatment participation is not consistent among the broad range of jurisdictions in Minnesota.

The process of assessing treatment progress for the purpose of civil commitments may be further complicated by offender disclosures during treatment. Individuals who meaningfully participate in treatment often make appropriate disclosures of abusive past behavior that had not previously come to the attention of the legal system. These disclosures are highly encouraged in the course of treatment as they provide valuable information on which to base more complete treatment and supervision planning. This information, however, may also contribute to the demonstration of a "course of harmful conduct" which is a prerequisite for civil commitment. In this way, treatment participation that may otherwise have been interpreted as reducing a sex offender's risk for reoffending may be offset by treatment-related disclosures that increase the individual's likelihood of being civilly committed.

Finally, we note that the level and type of resources provided in the MSOP may simply be the right level and type needed by some offenders. In accordance with the risk/needs principles, an offender's level of risk should be "matched" with a corresponding level of risk management resources (including treatment). The quality of an offender's participation in treatment and the level to which the offender's treatment needs are matched appropriately with the intensity and design of the program should be considered in decisions to manage risk but in balance with all other relevant factors. In some cases, the MSOP may be the only appropriate treatment option for a given offender because of its unique design, approach, and duration of the program along with the extensive release components that are designed into the program.

Section IV: Review of Prior Legislative Report Recommendations

The topical team reviewed several prior reports regarding sex offender issues in the state of Minnesota including: the "Civil Commitment Study Group 1998, Report to the Legislature, January 1999"; "Sex Offender Policy and Management Board Study, December 2000"; the "Governor's Commission on Sex Offender Policy, January 2005"; and the Office of the Legislative Auditor's "Community Supervision of Sex Offenders, January 2005". The following recommendations from each report are relevant to the topical team's recommendations in the subsequent section.

In the 2000 "Sex Offender Policy and Management Board Study," a section was included on recommendations made by judges to improve the current system of managing sex offenders:

- Increased funding for treatment of offenders (although a few judges reported that they didn't believe that treatment was effective in reducing recidivism); and
- More treatment options.

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[17] We note for this discussion that the actuarial risk assessment tools are those that are used most broadly in assessing sex offender risk and yet they are not especially sensitive to changes in offender risk over time. The more recently developed "needs" assessment (dynamic risk) tools are designed to account for factors that are changeable.

From the 2005 "Governor's Commission on Sex Offender Policy, January," two different sections included recommendations relevant to this section:

Civil Commitment Practices:

- Establishing a Continuum of Structured Treatment Options. Commission Members believe that any patients transitioning from civil commitment should be bounded at all times by a strong and mutually reinforcing set of security measures – including supervision agents; highly structure living facilities; and electronic monitoring, Global Positioning Services and polygraph services.

Funding Issues:

- Moving toward a statewide approach to sex offender management. The Legislature should work toward achieving greater uniformity across Minnesota in supervision practices, treatment options, treatment infrastructure and the assessment of sex offenders.

From the Office of the Legislative Auditor's 2005 report "Community Supervision of Sex Offenders":

- Finding**:** The Minnesota Department of Corrections conducts little statewide oversight of community-based sex offender treatment programs.
  Finding**:** State law and administrative rules do not specify the program elements that comprise outpatient sex offender "treatment."

Recommendation**:** The Legislature should require DOC to promulgate state rules that specify basic program elements for community-based sex offender treatment programs.

- Finding**:** Adjusted for inflation, state spending for community-based sex offender treatment has declined in recent years.
  Corrections agencies that supervise the majority of Minnesota's sex offenders expressed serious concerns about the availability of community-based treatment resources, especially for offenders on supervised release.
  Offenders on supervised release who need intensive treatment are often referred to less intensive "support groups."
  Recommendation**:** The Legislature and Minnesota Department of Corrections should take steps to ensure that sex offender treatment funding is more available for offenders on supervised release, consistent with the department's statutory obligation to provide appropriate services for this offender population (Minn. Stat.(2004) §241.67, subd. 3).

While there is a range of recommendations represented in these reports, several primary themes emerged. The most pronounced themes are congruent with this team's findings, focusing on developing and sustaining a strategically designed system[18] of community treatment and supervision to manage sex offenders, in part through adequate funding mechanisms and the implementation of treatment standards for community programs.

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[18] Including a range of treatment and supervision levels of intensity designed to match the range of risk presented by this population.

Section V: Discussion and Recommendations

Minnesota is one of 20 states maintaining civil commitment programs for sexual offenders as part of a broader strategy to manage the risks presented across the continuum of sexual offenders. In accordance with risk/needs principles, these programs are designed to provide treatment for the state's highest risk sexual offenders in secure settings. The programs are expensive to maintain and have been expanding because there are more sexual offenders entering them than are being released. These SVP programs have survived legal challenges because they are designed to provide treatment that has the potential for individuals meaningfully participating in them to reduce their risk sufficiently to be released back into the community.

Treatment systems in Minnesota have the potential to further reduce the need for civil commitments and to help support the appropriate release of some civilly committed individuals when they have made sufficient progress to warrant transition to society from MSOP. In either case, these strategies result in increased reliance on community-based treatment to manage higher risk sexual offenders than has been the case to this point. To make this shift responsibly, Minnesota should work to strengthen its community-based treatment options in several ways. These changes will require additional resources but it is likely that these additional costs will be more than offset through reductions in expected future MSOP operating costs and capital costs associated with program expansions.

Strengthen Community-Based Treatment Resources

RECOMMENDATION: *Create statewide standards for all community-based treatment.*

Treatment guidelines for programs that receive DOC subsidies for community-based treatment are in place; however, no statute-based standards apply to all programs regardless of funding source. The clinical and legal basis for MSOP is that the program will release individuals who successfully complete treatment and there are several clients who are close to earning provisional release. As the program releases committed individuals back into our communities, it will be critical to have a strong network of high quality and appropriately trained treatment providers who can help these individuals maintain the progress they have made during their residential treatment at MSOP and to also help them succeed in dealing with new situations and stresses they will face once released. Currently, no statewide standards are in place for the provision of community-based sex offender treatment that apply to all programs (including those that are not state subsidized) and no mechanisms for data collection or tracking non-grant funded programs. At minimum, Minnesota should consider developing standards for the provision of community-based treatment services for all sexual offenders.

RECOMMENDATION: *Develop mechanisms and systems to improve coordination and continuity between treatment providers.*

The overall quality of treatment in Minnesota is high yet within concurrent systems the community-based, prison and civil commitment treatment programs function in relative isolation from each other. The grants provided by the DOC for community-based treatment do offer opportunities for some coordination and some level of oversight yet this is limited. It is recommended that statute-based standards and policy changes be made to facilitate care coordination between programs that includes increased communication and programmatic continuity. This effort could be supported by a state-funded position created with the responsibility to provide a level of oversight across Minnesota's continuum of treatment services as well

as facilitating cross-system communication, program continuity, standards of quality, data collection, and information sharing.

These mechanisms should include the capacity to collect and track data across all state systems (DOC, DHS, Department of Public Safety, Courts) so that case progress and outcome can be analyzed over time. This requires the development of data management systems that allow state agencies to track individuals across systems to allow analysis of the "course of probation and treatment services" to be documented and available for analysis of effectiveness over time.

Review the Relationship between Treatment Processes and Civil Commitment

The second set of recommendations is related to the need for further study of the relationship between current treatment processes and civil commitment in Minnesota.

RECOMMENDATION*: Conduct a study of civil commitment decisions related to individuals who have successfully participated in prison- or community-based treatment.*

Evaluations of Minnesota's community and prison-based treatment systems show they are effective in reducing risk. While it is reasonable and likely that sexual offenders who successfully participate in treatment programs are less likely to need to be civilly committed, insufficient data exists at this point to draw clear conclusions on whether, in fact, this is currently true in Minnesota. Most civilly committed sexual offenders have already participated in more than one sex offender program prior to their commitment. Treatment is an extension of an ongoing assessment process and sometimes provides additional information that result in increased assessed risk. This is most clearly the case in treatment failures. Further study is needed of cases where an individual successfully participates in treatment and is nevertheless committed. While in some cases additional treatment within Minnesota's civil commitment program is needed to adequately address a given offender's higher level of risk, not enough is known about how these cases are evaluated in Minnesota's courts or whether the "weighting" of treatment progress and success is appropriately balanced against the risks presented by these individuals. The evaluation of the use of "needs assessments" (dynamic risk) by forensic evaluators should be included in this study.

It may also be that courts are reluctant to return some higher risk offenders to the community, despite their treatment progress due to a lack of higher intensity community-based treatment options (residential, day-treatment) where these offenders could continue their treatment process.

RECOMMENDATION*: Conduct a study of treatment-related disclosures.*

Another area deserving of further study is how treatment-related disclosures are considered by the courts. Sexual offenders often have additional offense behaviors and additional victims that have not come to the attention of the legal system. Offenders are strongly encouraged and frequently do disclose additional offending history as part of their treatment. Having a complete offending history assists treatment and supervision professionals in creating comprehensive treatment and supervision plans. Although treatment-related disclosures help in the effective management and treatment of these individuals, the disclosures may also strengthen commitment cases against them, creating additional evidence of a "course of harmful conduct." If this is the case, it is an unintended and unfortunate consequence for offenders who engage in and meaningfully participate in treatment end up being at a disadvantage when

commitment decisions are made compared to those offenders who do not participate in treatment or who refuse to be forthright. Further study of this issue is warranted.

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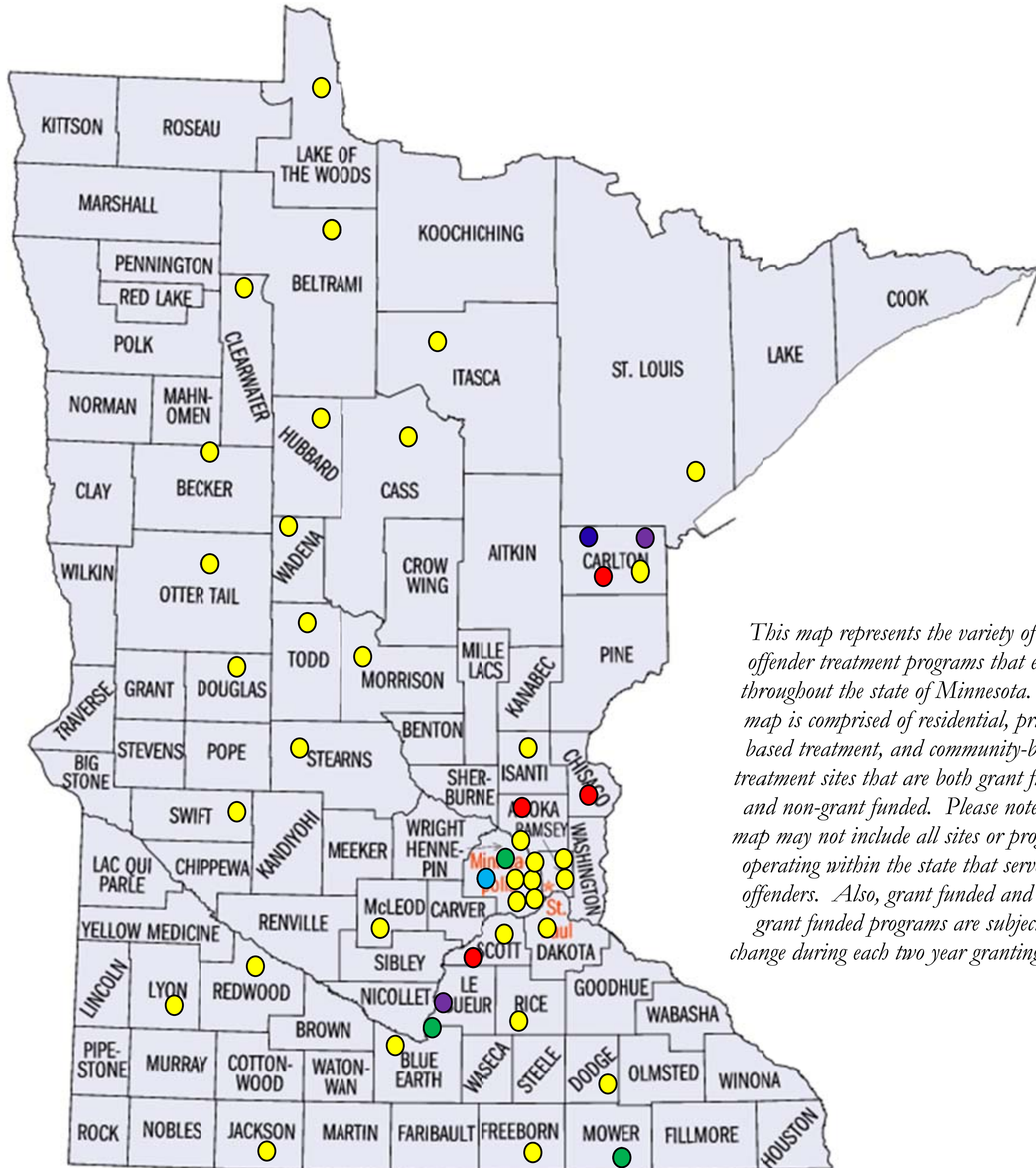
APPENDIX A: Treatment Continuum in Minnesota



This map represents the variety of sex offender treatment programs that exist throughout the state of Minnesota. The map is comprised of residential, prison-based treatment, and community-based treatment sites that are both grant funded and non-grant funded. Please note: the map may not include all sites or programs operating within the state that serve sex offenders. Also, grant funded and non-grant funded programs are subject to change during each two year granting cycle.

Treatment Continuum in Minnesota

- Community Outpatient Private Practice Programs (COPPP)
- Community Outpatient Structured Programs (COSP)
- Community Inpatient Residential Program (CIRP)
- Sex Offender Treatment Programs within Department of Corrections Facilities (SOTP)
- Civil Commitment Treatment Program-Minnesota Sex Offender Program (MSOP)
- MSOP-Department of Corrections Site Program (MSOP-DOC)

APPENDIX B: Civil Commitment Sex Offender Program Information

The majority of programs utilize Cognitive Behavioral Therapy (CBT; most popular 83%; 15 states);

Relapse Prevention (61%; 11 states); Good Lives (44%; 8 states)

State	Year Opened	Current Census as of 2009	Treatment Philosophy – Self Identified by Program
Arizona	1995	60**	-CBT* -Relapse* -Prevention* -Arousal Management*
California	1995	699	-CBT* -Relapse Prevention* -Risk Management* -Psycho Education* -Behavioral Reconditioning*
District of Columbia	NA	NA	Currently not available
Federal Bureau of Prisons (BOP)	NA	2	Currently not available
Florida	1998	450***	-Good Lives* -Risk/Need/Responsivity* -YWCA's Life skills*
Illinois	1997	224	Currently not available
Iowa	1998	80	-CBT* -Good Lives* -Relapse Prevention* -Risk Management*
Kansas	1994	183***	-CBT* -Good Lives* -Relapse Prevention* -Motivational Interviewing* -Self-Regulation Theory* -DBT*
Massachusetts	1999	240***	-CBT* -Relapse Prevention* -Psycho Education*
Minnesota	1994	580 (8/29/2010)	-CBT* -Motivational Interviewing* -Relapse Prevention*
Missouri	1999	132	-CBT* -Good Lives*
Nebraska	2006	145	-CBT* -Relapse Prevention*
New Hampshire	2006	2	-Relapse Prevention*
New Jersey	1998	385***	-CBT* -Good Lives* -Relapse Prevention* -Motivational Interviewing*

State	Year Opened	Current Census as of 2009	Treatment Philosophy – Self Identified by Program
New York	2006	100***	-CBT* -Good Lives* -Relapse Prevention* -Risk/Need/Responsivity* -Containment Model*
North Dakota	1997	55	-CBT* -Good Lives* -Relapse Prevention* -Social Learning* -Therapeutic Community*
Pennsylvania	2003	24***	-CBT * -Arousal Management * -Behavioral Contracting*
South Carolina	1998	118**	Currently not available
Texas	1999	175	-CBT*
Virginia	1999	214	-CBT* -Good Lives* -Risk Management* -Self-Regulation Theory* -Pathways* -Containment*
Washington	1990	297**	-Self-Regulation Theory*
Wisconsin	1994	383**	-CBT* -Relapse Prevention* -Social Learning*

*Information obtained by an evaluation of risk assessment screening, civil management and treatment of civilly managed sex offenders. This information was presented in-house to the New York State Office of Mental Health Division of Forensic Services on March 5, 2010

**Information obtained by direct contact with the program in July 2009

***Information referenced from 2009 SOCCPN survey of SVP Programs

APPENDIX C: Matrix Factors and Criminogenic Needs

Matrix Factor	**Criminogenic Need/Dynamic Risk Factor**
Group Behavior	Resistance to Rules/Supervision Negative Social Influences Poor Self-Regulation General Hostility Hostility toward Women
Attitude toward Change	Offense Supportive Attitudes Antisocial attitudes and behavior
Self-Monitoring	Poor Self-Regulation Antisocial attitudes and behavior Impulsivity Sexual Preoccupation Sexually Deviant Interests Sexualized Coping
Thinking Errors	Offense Supportive Attitudes General Hostility Hostility toward Women Antisocial attitudes and behavior
Pro-Social Problem Solving	Negative Social Influences
Emotional Regulation	Poor Self-Regulation Impulsivity
Interpersonal Skills	Emotional Congruence with Children Poor Adult Attachment Negative Social Influences
Cooperation with Rules	Resistance to Rules/Supervision Antisocial attitudes and behavior
Sexual Functioning	Sexual Preoccupation Deviant Sexual Interests Sexualized Coping
Productive Use of Time	Unstable Work History

CIVIL COMMITMENT PROCESS

Civil Commitment Topical Team Charge and Participants

The charge of the civil commitment topical team was to consider the commitment process for Sexually Dangerous Person (SDP) and Sexual Psychopathic Personalities (SPP) in light of the growth and cost of the Minnesota Sex Offender Program. It was determined three separate points need to be discussed in the process that is directly related to cost and growth: referrals for civil commitment and the legal process; and successful reintegration of MSOP clients into the community. This was completed by reviewing multiple information sources: past Minnesota reports and recommendations; other SVP programs nationwide; and current Minnesota statutes and laws. The team was coordinated by the Department of Human Services and chaired by MSOP Executive Clinical Director Jannine Hebert who consulted with various stakeholders within the Department of Corrections, Attorney General's Office, and county attorneys.

Section I: History of Civil Commitment Law

In 1939, Minnesota enacted the Psychopathic Personality law providing for indefinite civil commitment of "dangerous" sex offenders for treatment. From April of 1939 until September of 1994, the Psychopathic Personality (PP) commitment was the only sex offender category of commitment. The elements required for commitments as PP were that the individual:

> [1] Engaged in a habitual course of misconduct in sexual matters, and evidenced an
> [2] Utter lack of power to control the individual's sexual impulses and, as a result, was
> [3] Likely to attack or otherwise inflict injury, loss pain or other evil on the object of the individual's uncontrolled and uncontrollable desire.[19]

In 1994, the Legislature replaced the PP category with the Sexually Psychopathic Personality (SPP) category. The statutory SPP commitment category is defined as:

> *"…the existence in any person of such conditions of emotional instability, or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of personal acts, or a combination of any of these conditions, which render the person irresponsible for personal conduct with respect to sexual matters, if the person has evidenced, by a habitual course of misconduct in sexual matters, an utter lack of power to control the person's sexual impulses and, as a result, is dangerous to other persons."*[20]

At the same time the Legislature also created the entirely new SDP commitment category. An SDP is defined as a person who:

> [1] has engaged in a course of harmful sexual conduct as defined in subdivision 7a;
> [2] has manifested a sexual, personality, or other mental disorder or dysfunction; and
> [3] as a result, is likely to engage in acts of harmful sexual conduct as defined in subdivision 7a.
>
> > (b) For purposes of this provision, it is not necessary to prove that the person has an inability to control the person's sexual impulses.[21]

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[19] *State ex rel Pearson v. Probate Court*, 287 N.W. 297, 302 (Minn. 1939), *aff'd*, 309 U.S. 270, 277 (1940).
[20] Minn. Stat. section 253B.02, subd. 18b.
[21] Minn. Stat. section 253B.02, subd. 18c.

Section II: Referral Process

The Department of Corrections (DOC) implements Minn. Stat, 244.05 Subd. 7 through DOC policy # 205.200[22] and in accordance with this policy established a SPP/SDP Screening Committee and Independent Legal Counsel as entities that make recommendations to the Commissioner of Corrections on whether or not to forward a case to the county attorney based upon a preliminary determination that a petition for commitment may be appropriate.

DOC Policy #205.200 utilizes Minn. Stat. 253B.02 for definitions of Sexual Psychopathic Personality, Sexually Dangerous Person and Harmful Sexual Conduct. Due to the need for operational specificity not provided in statute, the DOC policy provides specific elements to be considered in the screening process. These elements are based on case law, risk assessment actuarial instruments, as well as corrections and clinical judgment.

Minn. Stat. 244.05 Subd. 7 requires DOC to make a preliminary determination on those offenders to be released who are convicted under section 609.342, 609.343, 609.344, 609.345, 609.3453, and 609.108 who are determined to be in a high risk category. This language requires the DOC to review those specified categories of offenders and does not exclude additional categories. Therefore in addition to the offenders required by statute, the DOC policy requires a preliminary determination on offenders who are transferred or move to Minnesota from other states or federal facilities.

All of these cases meet at least one of the following factors or have a moderate or higher score on an actuarial risk tool (MNSOST-R, STATIC 99):

- Two or more sex offense convictions
- Length of sex offending history indicates higher risk
- Force or threat ever used to accomplish a sex offense
- Victim of the offense was a stranger
- At least one sex offense and one crime of non-sexual violence
- Disciplined for sexual behavior during current incarceration AND has a single cell restriction for Danger to Others
- Sex offender recidivist
- Female offenders with a current or prior sex offense or sex related offense
- Any offender charged or convicted for possession, sale and/or distribution of child pornography
- Offenders who raise special concerns (i.e. prison discipline, declarations of intent to offend, self-admissions of additional victims, etc.)

Once considered and reviewed, approximately 20% of these cases are forwarded to the Screening Committee and Independent Legal Counsel for review. The Screening Committee and Independent Legal Counsel review cases in light of the case law (Linehan I and IV) and apply the SDP/SPP criteria to the case. Approximately 70% of the cases reviewed by the Screening Committee are referred to counties for civil commitment. For example, in 2009, 758 cases were considered and of those, 173 were reviewed by the Screening Committee and 114 referrals were made to the counties. On average, 50% of the referrals to counties result in commitments.

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[22] "Sex Offender Civil Commitment Screening" www.doc.state.mn.us/DOcpolicy2/html/DPW_Display.asp?Opt=205.200.htm As accessed on August 16, 2010.

The current referral process is fairly prescriptive. The Risk Assessment Community Notification (RACN) unit of DOC has developed a sophisticated and efficient process of review and referral. The parameters are consistent with statutory language and procedures are outlined in DOC policies. The statutes provide a broad overview but the details are in the policies. By evaluating the criteria as detailed in policy and providing clearer definition of statutory language, the number of referrals to the counties could be decreased. One example would be regarding the application of the Sexually Dangerous Person criteria "course of harmful sexual conduct." A second fairly all-encompassing criterion is the application of a mental disorder/dysfunction. Application of diagnostic criterion for sexual offenders remains controversial as it relates to predicting risk.

In 2008, 44 Minnesota counties pursued civil commitment of individuals as SDP or SPP (see Appendix A). Each case was heard by a district court judge who is charged with applying the statutory criteria. The frequency of which each county processes an SDP or SPP case varies significantly. Some judges or county attorneys may participate in one or two cases per year. These cases involve complex legal issues and sophisticated clinical issues and maintaining expertise in these unique cases can be challenging when they are considered on an infrequent basis.

Section III: Reintegration

Nationally, conditional releases for civilly committed sexual offenders are few. (See Appendix B of Treatment section). Several civil commitment programs have not released any clients. It is not uncommon for successful completion of treatment for the most motivated civilly committed client to take an average of eight years. Conditional releases must be approved by the courts with or without the support of treatment providers. Weighing the importance and potential risk of such a decision is significant and preparing clients for possible conditional release is equally important. MSOP has developed a unique and thorough process for preparing clients who have successfully completed treatment for reintegration.

As outlined in the treatment section of this report, MSOP has three phases. Clients who have successfully participated in treatment and demonstrated meaningful change advance to Phase III of treatment. This final phase occurs in St. Peter in either the Alternative Program or MSOP Supervised Integration (MSI). The treatment focus for clients in this later stage is to internalize and apply their treatment concepts in more typical or normalized settings. Many of these clients have lived in secured settings for decades in both DOC and MSOP. It is during this transitional period that clients learn to manage their risk factors and stress level in new and unfamiliar environments for successful reintegration into the community.

Once clients are moved to St. Peter and are in the transitional phase of treatment, they wear ankle bracelets for the Area Monitoring System (AMS) which allows MSOP staff to track clients anywhere on the St. Peter campus. To progress through the transitional period of treatment, clients obtain and maintain levels of privileges:

1. On-campus walks accompanied by staff.
2. Off-campus outings into the community accompanied by staff.
3. On-campus walks, unaccompanied.

All forays outside of the secure perimeter are approved by the treatment team and are based on individual treatment plans. MSOP staff meets with clients after every outing to "de-brief" the event and discuss the application of management strategies. Through this process, clients are safely and gradually exposed to increased responsibility and appropriate challenges to assist them in eventual provisional discharge.

Community Preparation Services (CPS) is the final component in the transitional process. In order for clients to be placed in CPS, they must petition the Special Review Board (SRB)[23]. The SRB is provided information regarding the client's risk and treatment progress as part of the decision making process. The SRB forwards their recommendation to the Supreme Court of Appeals Panel (SCAP) who makes the final determination. If a client is placed in CPS by the court, they move to a residence outside the secure facility on the St. Peter campus. MSOP has two CPS residences – a three-bedroom single family home that can accommodate up to five individuals and a building wing with four rooms that can house up to eight individuals. Both are home-like settings with shared bedrooms, full kitchens, living rooms, laundry facilities and accessible yard space. All CPS clients are monitored on both AMS as well as Global Positioning System (GPS). Clients in CPS maintain their level of privileges and eventually progress to supervised outings beyond the immediate area. Clients develop treatment plans that may include attendance at local Alcoholics Anonymous groups, volunteering, community-based treatment services and developing community support networks for eventual provisional discharge. Clients sign a reintegration agreement and violations of this agreement may result in a return to living inside the secure perimeter.

If a MSOP client successfully petitions the court for a provisional discharge, they will likely reside in a halfway house in the community where they will continue their adjustment to society and establish employment. MSOP will have the primary responsibility for monitoring and supervision throughout provisional discharge. In addition to GPS electronic monitoring, MSOP field agents will make daily face-to-face contact during the client's first 30 days in the community. In the case of clients who still have time remaining on their prison sentences and are dually committed to DHS and DOC, MSOP will coordinate supervision and enforcement roles with DOC/Community Corrections.

MSOP field agents will provide case management services in coordination with the relevant county and halfway house case managers. Agents will assist clients with the search for long-term housing and employment and will be available to drive them to appointments. As clients adjust to their new environment, MSOP will assist in securing longer term housing after the halfway house. Clients will continue out-patient treatment and/or aftercare in the community according to their needs as outlined in their individual treatment plan. Clients' progress while on provisional discharge will be reviewed quarterly by the reintegration team and supervision will be adjusted according to the needs and progress of the clients.

Alternative Programming

By definition, MSOP clients present with challenging treatment issues. Some of these individuals have especially complex clinical needs that require specialized interventions. Approximately 100 of the

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[23] Minnesota statute 253B.18, subd. 4c establishes the special review board. 253B.185, subd. 9 provides the procedures for the SRB consideration of SDP/SPP petitions.

MSOP clients have cognitive, neurological or learning challenges that prevent them from being successful in a conventional treatment track. Consistent with the Risk/Needs/Responsivity model, MSOP has a specialized treatment track for these clients. Conventional sex offender treatment programming relies heavily upon written assignments and talk therapy, modalities that, while effective for many, can be difficult for some clients, especially for sustained periods of time. The Alternative Program provides comprehensive sex offender treatment programming to individuals who find conventional approaches difficult or even impossible to navigate. The programming seeks to: (1) adapt the treatment process to allow for optimal understanding and client engagement; and (2) ensure that the integrity of the treatment process is not undermined or reduced by these adaptations.

Many of the individuals in the MSOP Alternative Program have genetic or acquired intellectual disabilities (e.g., limitations due to traumatic brain injuries), including limited intelligence, attention deficits, learning disabilities, and/or slow mental processing, poor retention and poor working memory. The average IQ lies in the low- to mid-70s; some lie as low as the low-50s. Insight and abstract thinking can be incredibly difficult for individuals with low intellectual functioning, who tend to be very concrete thinkers. Those with average or higher IQs are often challenged by poor reading and writing skills due to limited education, English as a second language, and/or expressive or receptive language problems.

In addition to intellectual limitations, many Alternative Programming clients experience psychiatric challenges that, along with medication side effects, can interfere with memory and with the ability to track conversations and to comprehend and manage treatment assignments. Forty percent of the individuals in the Alternative Program have been diagnosed with a mood disorder (mostly depression, anxiety and bipolar spectrum disorders), and nearly one out of five have a thought disorder (schizophrenia and others). Thought disorders contribute to poor reality testing and tracking in individual and group settings, communication problems and difficulties with trust/paranoia. Those who have acquired intellectual limitations through a traumatic brain injury may experience particular challenges with impulsivity, poor planning skills, decision-making and overall compromised executive functioning.

When it comes to sexual offense histories and related treatment needs, individuals in the MSOP Alternative Program are more similar to their conventional programming counterparts than they are different. Intellectual disabilities and under-socialization can produce a greater emotional identification with children, but to assume that all clients in the Alternative Program follow this description would be a gross over-generalization. Approximately 1/3 of the Alternative clients have been diagnosed with chemical dependency, and many (including those who are not chemically dependent) have abused substances as part of their criminal acts. Many have high psychopathic traits and personality disorders (antisocial, narcissistic, borderline, dependent, to name a few) are commonplace.

With the many special needs these individuals have, a large number (around 70%) have spent decades in foster care, state hospitals, reformatories, and residential treatment programs as well as prisons. They tend to be highly institutionalized. For this reason, they present unique challenges in reintegration. A certain number will likely continue an institutionalized existence even after leaving MSOP, albeit in a somewhat less restrictive and less costly setting, perhaps for the remainder of their lives.

Provisional Discharge

As discussed in the treatment section of this report, Minnesota has inconsistent community resources for sexual offenders. Minnesota has no standards for outpatient treatment programs and many housing and social services are located primarily in the metropolitan area.

MSOP clients placed on provisional discharge by the courts are in need of services that will meet their housing, supervision and treatment/aftercare needs. Professional literature indicates that successful reentry efforts increase the potential for community safety with all offenders and individuals successfully integrated into a community become productive members of society. The good lives model (Ward, Mann, Gannon 2007) reminds us that all humans benefit from the fundamental desire to obtain purposeful belongingness.

Creating obstacles related to securing fundamental human needs such as housing and financial security is counterproductive to maintaining community safety. Knowing where offenders reside allows for appropriate supervision and management. Developing secure social networks creates personal accountability and responsibility to others.

Section IV: Discussion and Recommendations

Civil commitment programs for sexual offenders are an expensive yet necessary tool in an effective, comprehensive statewide management strategy. The challenge for the State of Minnesota is to utilize MSOP efficiently while maintaining public safety in a fiscally responsible manner. Opportunities exist to impact the future cost and growth of MSOP by making modifications and revisions in the current process of civil commitment. Evaluating the application of commitment criteria in the referral process would impact the number of new clients admitted to MSOP. Enhancing coordinated community based resources would increase the ability to manage this challenging population at a decreased cost. Once modifications and new policies are in place, an ongoing evaluation of the statewide management system for sex offenders would assist in maintaining efficiency and better ensure public safety.

RECOMMENDATION: *Establish a panel of judges to hear all civil commitment petitions for sexual offenders.*

These cases not only involve complex legal issues, but also involve complex issues of risk determination, interpretation of meaningful change, and treatment participation. In order to achieve consistency and to maximize state resources while streamlining the commitment process, it would be advantageous to assign SDP/SPP commitment cases to a dedicated panel of judges who have specialized knowledge and interest in this area of law. Centralization would provide the opportunity for developed specialization in applying statutory criteria. By maintaining a small number of judges to regularly hear the cases, pertinent updates from the field of risk assessment and treatment could be more readily disseminated.

The 2005 Governor's Commission on Sex Offender Policy Final Report recommended:
"The Legislature should encourage the Minnesota Supreme Court to use existing statutory authority to establish a specialized panel for civil commitments." Under *Minnesota Statutes* 253B.185 (4), the Minnesota Supreme Court is authorized to "establish a panel of district judges with statewide authority to preside over commitment proceedings of SPP/SDP. Centralizing the handling of all civil commitment cases would increase the uniformity in criteria application, and create a small group of judges to develop

and maintain expertise in this area of specialization including remaining abreast of professional research in the area of risk assessments."

RECOMMENDATION: *Establish stronger community network of treatment, resources and accountability for sexual offenders.*

The State of Minnesota must develop alternatives to MSOP that maintain public safety. The current options for community-based treatment programs for the highest risk sexual offenders are limited. Advanced training and ongoing monitoring is needed to ensure appropriate standards of care. Once there is a "track" in the community to appropriate support and monitor offenders be they in reintegration, MSOP cost and census will go down. The 2005 Office of the Legislative Auditor's Report on the Community Supervision of Sex Offenders: "There are strong arguments for increased state investment in sex offender assessment, supervision, treatment, and housing."

RECOMMENDATION: *Develop community-based housing options for sex offenders on court-ordered provisional discharge in the community.*

The MSOP reintegration design places MSOP clients on provisional discharge temporarily in a half-way house to assist in their reintegration and gradual reintroduction into the community after many years of institutionalization. Following successful placement at a half-way house, MSOP clients will be placed in more permanent housing. Housing resources for sex offenders in Minnesota are currently limited and without housing, offenders become homeless and seek temporary accommodations. Appropriate housing that maintains public safety would be necessary for sexual offenders on provisional discharge or release from DOC. Intentionally designed housing for this unique population would promote effective ongoing supervision and community safety. Incentives to develop housing statewide would distribute provisionally discharged MSOP clients more evenly across the state.

APPENDIX A: Civil commitment referrals from DOC and actions taken, 2008

Data Definitions for SPP.SDP Referrals

County Did Not Proceed:	An affirmative decision provided by the county attorney that they will not proceed with a petition at this time.
Under Review:	County attorney has indicated the case is under review or DOC has not received a status report from the county attorney.
Hold:	Court order to detain the offender pending further action.
Petition Dismissed:	The court dismissed the petition based on a motion to withdraw the petition from the county or the decision is based on the merits of the case.

County	Referred by DOC		Committed	County Did Not Proceed	Under Review	Hold	Petition Dismissed
Anoka	9		1	7	1		
Beltrami	4		2	2			
Benton	1			1			
Blue Earth	1						1
Brown	1			1			
Carlton	1			1			
Cass	2		1	1			
Chisago	1			1			
Clay	4		2	1			1
Crow Wing	2		1				1
Dakota	5		2	3			
Faribault	1					1	
Fillmore	1					1	
Goodhue	2			1			1
Hennepin	24		3 (1 as MI & D*)	19		1	1
Itasca	1			1			
Jackson	1		1				
Kanabec	2		1				1
Koochiching	1			1			
Le Sueur	2		1			1	
Lyon	1		1				
Mahnomen	1			1			
Martin	3		2				1
Mille Lacs	2			1		1	
Mower	1		1				
Nicollet	1						1
Olmsted	5		1	1	1		2
Pennington	1		1				
Pine	1						1
Polk	1				1		
Ramsey	16		6 (1 as MI & D)	6	1		3

Ramsey/Sherburne	1			1			
Rice	2			2			
Roseau	2			1		1	
Scott	3		1	2			
Sherburne	3		2		1		
St. Louis	6						
Stearns	1		1				
Todd	3			1	1		1
Wabasha	1			1			
Washington	2		1	1			
Washington/Ramsey	1		(1 as MI & D)				
Watonwan	2		1		1		
Wilkin	1			1			
Winona	2			1		1	
Wright	4			2			2

* Mentally Ill and Dangerous

SEXUAL ABUSE PERPETRATION PREVENTION

Prevention Topical Team Charge and Participants

The prevention topical team was included to focus on preventing the perpetration of sexual abuse as it pertains to decreasing the cost and managing the growth of MSOP. Coordinated by the Department of Human Services and chaired by Patty Wetterling from the Minnesota Department of Health (MDH) and Cordelia Anderson of Sensibilities, Inc., the team reviewed past reports as well as a recent five year sexual violence prevention plan by MDH regarding strategies for preventing the perpetration of sexual abuse. This team made specific recommendations for policy initiatives that the state of Minnesota could pursue to strengthen and spearhead prevention efforts.

Section I: Introduction

"In the brain as in the economy, getting it right the first time is ultimately more effective and less costly than trying to fix it later." - James Heckman, Nobel Laureate Economist[24]

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[24] National Scientific Council on the Developing Child, Perspectives: The Cradle of Prosperity. (2006). Retrieved 10/29/10 from www.developingchild.net.

Working Upstream

A very prevalent metaphor used in the field of public health illustrates a needed shift in the prevention of sexual violence and abuse. A fisherman sees someone being swept downstream struggling to swim and fighting for breath. He dives in and pulls the near-drowning individual to the safety of the riverbank. A few minutes later, another person floats downstream shouting for help and in desperate need of rescue. Again, the fisherman dives in and pulls them to safety. After several more people float down struggling to survive, the fisherman walks upstream to determine how so many people are in need of help. He discovers a hole in the bridge over the river. He fixes the bridge to ensure more people are not in danger of drowning.

Historically, public policy and public funding have responded to sexual violence after it has occurred. To deal with those who offend, the state has invested heavily in the criminal justice response by building prisons, increasing sentences and expanding the terms and conditions of civil commitment. For those victimized, they have been encouraged to report and to take actions to reduce their risks. Professional training has focused on how to identify signs that someone has been victimized or how to conduct better forensic interviews. These responses, though necessary, focus on pulling people from the river, not preventing the circumstances that pulled them in and downstream.

Section II: Public Health Approach to Prevention

Not only is the aftermath of sexual violence painful for all of those directly involved and affected, it is costly for all Minnesota residents. In 2005, sexual assault in Minnesota cost almost $8 billion or $1,540 per resident.[25] This figure includes costs to the criminal justice system; medical costs incurred to victims; and treatment and incarceration of offenders. A significant portion of this figure was attributable to the pain, suffering and quality of life losses to those affected by sexual violence. Given its scope and impact across communities as well as its financial toll, sexual violence affects entire populations either directly or indirectly.

The tools of public health have been increasingly employed when addressing sexual violence and its effects on entire populations. In 2001, the nation's top public health agency, the Centers for Disease Control and Prevention (CDC) began addressing sexual violence.[26] Public health is interdisciplinary and science-based drawing upon knowledge from many disciplines including medicine, epidemiology, sociology, psychology, criminology, education and economics and is concerned with approaches that address the health of a population rather than one individual.[27] By drawing on many fields and areas of expertise, public health has the ability to be creative in response to and the prevention of violence. Similarly to the ways in which public health efforts have prevented and reduced workplace injuries, infectious diseases, illness resulting from contaminated food and water, and reduced pregnancy-related complications, so too can these efforts be applied to the prevention of violence.[28] This application of the public health model is perhaps best summarized in the following:

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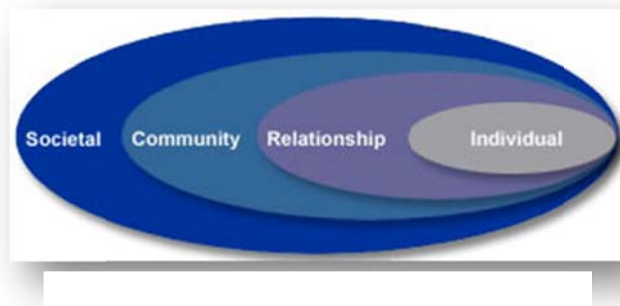
[25] "Costs of sexual violence in Minnesota", Minnesota Department of Health, July 2007
[26] "Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence," Virginia Sexual and Domestic Violence Action Alliance, August 2009
[27] "World report on violence and health", World Health Organization, 2002
[28] Ibid.

"This paradigm shift results in moving from medical treatment after the fact to prevention in the first place — and from targeting individuals to moving toward a comprehensive community focus. The imperative for this shift in thinking is best described by the psychologist and noted prevention advocate George Albee (1983), who noted that 'no mass disorder afflicting mankind is ever brought under control or eliminated by attempts at treating the affected individual.'"[29]

Violence is the result of a complex interplay of individual, relationship, social, cultural and environmental factors, therefore, it is important to understand how these factors are related in the public health approach. The ecological model is used to explore the relationship between the different factors and considers violence as the product of multiple levels of influence on behavior. [30]

The Ecological Model[31]



Individual – This level of the model tries to identify the biological and personal history factors that an individual has that contribute to their behavior. This primarily includes characteristics that can increase the likelihood of being a victim or a perpetrator of violence (i.e. impulsivity, low educational attainment, substance abuse, and prior history of aggression and abuse).

Relationship – A person's closest social circle - peers, intimate partners, and family members - all have the potential to shape an individual's behavior and range of experience. This level explores how these relationships can increase the risk for victimization and perpetration of violence.

Community – The third level explores the settings, such as schools, workplaces and neighborhoods, in which social relationships occur and seek to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence.

Societal – The fourth level looks at broad societal factors that help create an environment in which violence is encouraged or inhibited. These include social and cultural norms as well as health, economic, educational and social policies which help maintain economic or social inequalities between groups in society.

Targeting Prevention Efforts: When

In addition to looking at all levels of influence of violence in people's lives, public health also assesses when prevention interventions can be utilized. They can be grouped into three categories based on when they occur.

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[29] *Prevention is Primary: Strategies for Community Well-Being,2nd Edition.* San Francisco, CA: 2101
[30] Ibid.
35 Dahlberg LL, Krug EG. Violence-a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002:1–56.

Primary Prevention includes approaches and interventions that take place before someone has perpetrated sexual harm and before someone has been sexually victimized. This prevents someone from falling into the river in the first place.

Secondary Prevention includes immediate responses after sexual violence has occurred to deal with the short-term consequences. The fisherman rescuing people from the river is secondary prevention.

Tertiary Prevention includes long-term approaches to preventing future and further perpetration and victimization. This could be finding the cause of people falling into the river and repairing it so those same people do not fall in again.

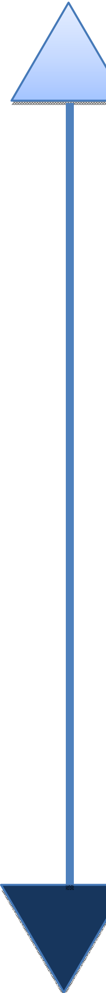
Public health also advises that interventions can be targeted to specific audiences. A ***universal*** strategy targets an entire population regardless of their risk for perpetration or victimization. A ***selective*** strategy is aimed at those who have a heightened risk of becoming a victim or perpetrator of sexual violence. An ***indicated*** strategy targets those who are victims or perpetrators.[32]

Section III: Opportunities for Prevention

The first step in the application of the public health model requires a definition of the problem. Sexual violence, like many types of violence, is incredibly complex in the variations of offenses, causes and responses. Due to the fact, that there is not one type of offense, perpetrator, victim, bystander or set of circumstances, there is not one method of prevention or intervention. Therefore, it is advantageous to explore the spectrum of sexual violence before determining appropriate interventions.

The following are several examples of different types of situations requiring different types of interventions and prevention. They are positioned on a spectrum to illustrate an increase in severity and harm but not to insinuate an expected progression of offenses. It begins with a child born healthy and free from any form of sexual abuse, exploitation or violence. Engaging prevention efforts for this boy means determining what is needed so that he never perpetrates sexual harm as well as ensuring that a level III sex offender never recidivates sexual harm and that we have interventions and prevention for every situation posed below.[33]

[32] "Sexual Violence Prevention: Beginning the Dialogue," Centers for Disease Control and Prevention, 2004.
[33] While not all acts of sexual violence and abuse are perpetrated by males, the vast majority of known and reported incidents are perpetrated by men.



A baby boy is born healthy and is blessed with loving parents willing and able to care for him.

A six year old is sexually abused. The mother is never reported. The abuse continues over a number of years. He is picked on at school and doesn't develop friends.

A nine year old boy witnesses his mother beaten by his father; he too is emotionally and physically abused by his father. He does poorly in school and is known for explosive anger and bullying and harassment of girls.

A 12 year boy is in trouble for bullying and is also known for his references to pornography and various ways that he's preoccupied with sex.

A man pays for sex with adult women and girls he knows to not be 18.

A man is not known to have molested a child but looks at child pornography for sexual arousal.

A man is primarily sexually attracted to prepubescent children but believes he can control it. He marries a woman with young children.

A man perpetrates against a young woman selecting her because she was intoxicated. She reports. During the investigation, it becomes clear she was not his first victim. He is charged and found guilty. He serves eight years and is getting out.

A man is using his power and anger to dominate women in his life. He is filled with rage, male privilege and entitlement. He's callous, unemotional and is hyper-sexual.

A man has committed more than one act of sexual aggression/abuse/assault. He's never been reported. He is unknown to the system.

A man has served a sentence for sex crimes. He has problems with drinking and other drugs. He experienced abuse as a child. He has other mental health diagnoses. He went through treatment but gamed his way through – never experienced high quality treatment. In prison, he was sexually assaulted. He is getting out.

In looking at the spectrum of opportunity for prevention, what intervention is needed to ensure each of these individuals does not perpetrate sexual harm or recidivate sexual harm? If all acts of sexual abuse, exploitation and violence could be prevented by one strategy, it would likely have been achieved by now and all the efforts to treat those victimized and those who perpetrate would be unnecessary. But as this continuum indicates, children are not born perpetrators of sexual violence and there is not one type of sexual offense or set of circumstances leading to sexual abuse. We know that environment makes a significant difference as do early adverse childhood experiences including sexual abuse, physical abuse, and neglect and witnessing domestic violence. Given the complexity and uniqueness of each case of abuse and violence, it is advantageous to assess the different components of each as a method of intervention. By assessing the risk for harm, we are more able to target interventions to a variety of abusive and harmful situations.

Risk Factors for Sexual Violence Perpetration

Risk factors are conditions or characteristics that increase the likelihood of the perpetration of sexual violence but do not necessarily cause sexual violence. Similarly, protective factors are conditions or characteristics that decrease the likelihood of sexual violence perpetration but a single factor does not

necessarily prevent sexual violence. These factors do not predict that a person will or will not become a victim or a perpetrator. They simply alert one to possibilities, so that preventive action can be taken; similarly to how a person whose family history puts him or her at risk for heart disease or breast cancer may change their health habits. Protective factors can also facilitate a range of positive outcomes.[34]

Examining risk factors from an ecological perspective can provide a more comprehensive understanding of how risks are interrelated. Each level may contribute to the risk of perpetration, and understanding the manifestation of these risk factors at each level provides a more complete picture of the etiology of sexually offending behavior.[35] This, in turn, allows us to determine appropriate methods of prevention and intervention based on risk.

Recent research has also delineated between "causal" and "correlated" factors.[36] For instance, alcohol use does not *cause* someone to perpetrate sexual harm but the effects of alcohol can create misperceptions of sexual cues as well as an increased sex drive. Therefore, alcohol use is correlated with perpetration.

The Centers for Disease Control and Prevention lists the following as Risk Factors for Perpetration:[37]

Individual Risk Factors

- Alcohol and drug use
- Coercive sexual fantasies
- Impulsive and antisocial tendencies
- Preference for impersonal sex
- Hostility towards women
- Hyper masculinity
- Childhood history of sexual and physical abuse
- Witnessed family violence as a child

Relationship Factors

- Association with sexually aggressive and delinquent peers
- Family environment characterized by physical violence and few resources
- Strong patriarchal relationship or familial environment
- Emotionally unsupportive familial environment

Community Factors

- Lack of employment opportunities
- Lack of institutional support from police and judicial system
- General tolerance of sexual violence within the community
- Weak community sanctions against sexual violence perpetrators

Societal Factors

- Poverty
- Societal norms that support sexual violence
- Societal norms that support male superiority and sexual entitlement
- Societal norms that maintain women's inferiority and sexual submissiveness

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[34] "Guidelines for the Primary Prevention of Sexual Violence & Intimate Partner Violence," Virginia Sexual and Domestic Violence Action Alliance, August 2009

[35] Patterson, Lindsey B., Kaufman, Keith L., Yogoda, Julie, and Sara J. Valenzeula. "Identifying Risk Factors Related to Sexual Violence" from *Preventing Sexual Violence: A Practitioner's Sourcebook.* Holyoke, MA: 2010

[36] Knight, Ryamond A., Sims-Knight, Judith, with contributions from Suzanne Brown-McBride. "Using Rapist Risk Factors to Set an Agenda for Rape Prevention" September 2009.

[37] http://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html

- Weak laws and policies related to gender equity
- High tolerance levels of crime and other forms of violence

By understanding risk at all levels of the ecological model, we not only dispel the myth that people are born sexual offenders, we increase the opportunities for prevention by intervening on risk. Increasing protective factors to decrease risk factors is a concrete step towards preventing the perpetration of sexual abuse.

Section IV: Review of Prior Legislative Report Recommendations

The following reports made recommendations specific to the prevention of sexual violence and abuse in Minnesota. These serve as indications that prevention is being increasingly discussed and considered when determining how best to deal with sex offender issues.

2005 Governor's Commission on Sex Offender Policy Final Report:

The Commission recommends:

"Examining in detail how the resources that are spent to prosecute and incarcerate sex offenders compare with the amount of public resources that are available to treat the victims of sex crimes and to prevent further sexual offending. As with other public safety programs, the Legislature should pursue a more uniform set of services across the state."

"Increasing attention to the prevention of sex crimes. While the potential long-term cost savings to the public health system from preventing sex crimes are large – as is the potential to avoid suffering by victims – specific strategies on how to break cycles of offending are less clear. The Department of Health's work on violence prevention is a valuable start; and more should be done to develop, research and discover effective prevention strategies."

2007 "Costs of Sexual Violence in Minnesota," Minnesota Department of Health:

"In Fiscal Year 2006, the state government spent $130.5 million on people known to have perpetrated sexual violence, while spending $90.5 million on those who were assaulted. Funding for offender treatment and supervision recently was boosted, but victim services do not reach every county. Nearly $823,000 of federal funds were spent changing societal norms to prevent sexual assault. … Sexual violence costs 3.3 times as much as alcohol-impaired driving in Minnesota. Policy recommendations aimed at preventing sexual violence BEFORE it occurs should be vigorously pursued, adopted or sustained."

2009 "The Promise of Primary Prevention of Sexual Violence," Minnesota Department of Health:

In 2008, the Minnesota Department of Health convened a group of practitioners and experts within the field of sexual violence and created a 5-year plan to prevent sexual violence and exploitation in Minnesota. This plan focuses on primary prevention strategies and calls on multiple individuals, communities and stakeholders to execute the adopted strategies for prevention.

The first of six goals is to strengthen social norms that encourage healthy and respectful relationships. We must send a strong message that sexual violence, exploitation and degradation are not acceptable and provide counter messaging encouraging healthy, respectful sexual development. We are working to build a critical mass of people, organizations and community leaders to carry the message from the grass roots to the highest level of leadership in Minnesota. Specific strategies to achieve this goal:

- Create multi-disciplinary, multi-cultural teams that develop the framing of our sexual violence prevention messages
- Teach and support the value of sexual respect and healthy relationships
- Provide tools to sexual assault programs to expand their prevention activities
- Ensure that people from under-represented communities (including people with disabilities, Gay Lesbian Bisexual and Transgender persons, racial and ethnic minorities) have opportunities to share their unique issues and solutions
- Engage men and male leaders to lead or join sexual violence prevention initiatives
- Network with state agencies to plan policy, analyze and disseminate information gathered
- Address the growing problem of teen dating violence
- Implement campus initiatives to prevent sexual violence on our Minnesota college campuses
- Implement and evaluate data and best practices for preventing sexual violence

Section V: Discussion and Recommendations

"A focus limited to personal behavior change ultimately fails us as a society because it narrows the possible solutions inappropriately . . . Personal choices are always made in the context of a larger environment. Prevention can address both ends of the spectrum."[38]

The above quote highlights the importance and significance of a population-based public health approach to sexual violence prevention. From birth to death, human beings make decisions based on their experiences as individuals, in relationships, with their communities and within a broader society. Prevention should address not only *both* ends of the spectrum, but more strategically, the *entire* spectrum. The inclusion of prevention in this legislative study and subsequent report is indicative of the urgency to prevent sexual violence before someone abuses and before someone is abused and to provide information about a scientifically and data-based approach to prevention. A complex web of social norms, environmental factors, peer influence and individual decision-making precedes an act of sexual violence, where ample opportunities exist for intervention and prevention.

The team's recommendations incorporate the application of the public health model including when interventions can be applied (primary, secondary or tertiary) and what audiences they will target (universal, selected and indicated).

RECOMMENDATION: *Allocate funding specifically to sexual violence prevention efforts and research as future cost-savings for the state of Minnesota.*

WHEN: Primary

WHO: Universal

This includes research, design, implementation and evaluation of perpetration prevention strategies as well as primary, secondary and tertiary efforts. Much remains unknown about how individuals become civilly committed sex offenders. In order to create prevention programs to decrease the size of the Minnesota Sex Offender Program, it is necessary to bolster research about MSOP clients and what types of interventions could have prevented their offending behavior.

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[38] Dorfman, L., Wallack, L., Woodruff, K. (2005) More than a message: Framing public health advocacy to change corporate practices. *Health Education & behavior.* 32(3), 320 – 336.

RECOMMENDATION: *Identify, assess and provide resources for children who have experienced trauma including victims of sex crimes and those who demonstrate sexual behavior problems.*

WHEN: Primary/Secondary

WHO: Selected

In an effort to decrease risk and increase protective factors, it is necessary to develop strategies for a coordinated response for assessment, treatment and recovery of children exposed to trauma. Accurate assessment of sexual behavior problems in children, adolescents and adults is critical to effective early intervention and treatment. Advocating for and treating individuals who are victimized will lessen their chances of re-victimization while treating individuals who perpetrate will lessen their chances of re-offense.

Outcomes expected:

- Identification of qualified professionals who can conduct quality assessments and provide early intervention and treatment for children and youth with sexual behavior problems throughout Minnesota.
- Training of a broad range of professionals to increase the numbers of those able to provide such assessments and services.

Outcomes expected:

- Employment opportunities
- Access to safe and consistent housing
- Intensive supervision as dictated by release plans
- Education for both adolescent offenders and adults should they pursue it
- Safety and support for families and community supports (e.g. faith and civic organizations)

BED SPACE OPTIONS

Bed Space Options Topical Team Charge and Participants

The charge of the bed space options topical team was to review space options at current state facilities and review possible options for future expansions based on projected growth. The team assessed existing buildings and determined next steps in an effort to decrease the cost and manage the growth of MSOP. The team was chaired by Dan Storkamp, Deputy Director, MSOP and additional team members included Lou Stender, Special Projects, MSOP; and Alan VanBuskirk, Facilities Operator, State Operated Services, DHS. The Departments of Administration and Corrections were also consulted.

Section I: Introduction and Methodology

The issue of potential bed space growth for the Minnesota Sex Offender Program has existed for several years. Past reports have focused on the extensive costs of civil commitment and providing treatment within MSOP which impacts decision-making around facility expansion and growth, but a specific recommendation regarding bed space options has not been included. In 1993, the Office of the

Legislative Auditor's report on "Psychopathic Personality Commitment Law" confirmed the growth and need for additional beds for the program:

> *"The 1993 Legislature approved construction of a new $20.05 million, 100-bed treatment facility exclusively for psychopathic personality commitments. The new facility is scheduled to open in Moose Lake in July 1995. The Legislature has also appropriated $8.5 million to increase security and expand capacity at the Minnesota Security Hospital at St. Peter by 50 beds. … Our projections are slightly lower than the Department of Human Services', but both projections suggest that the Moose Lake facility is likely to be near capacity when it opens (assuming all current PPs at the Minnesota Security Hospital are transferred there)."*

The team reviewed the projected growth in the program based on current laws, trends, and polices. The projection for the next 12 years is approximately 50 additional clients per year. Based on this projected growth, the team looked at two scenarios. The first is to develop options to address the immediate need for 50 additional beds by 2012. The second scenario is to develop options for either a 200 bed expansion to address four years of growth or a 400 bed expansion to address eight years of growth. The team then reviewed several options within each scenario including expansions at existing MSOP physical sites (Moose Lake and St. Peter), expansions at other state facilities (Brainerd and Moose Lake Correctional Facility), and utilizing other vacant state buildings. Many of these options were raised during the 2010 legislative session regarding the $47.5 million expansion of the MSOP facility in Moose Lake.

MSOP has developed different specialized treatment at each facility. The Moose Lake facility houses individuals involved in the civil commitment process, non-participants, and those participating in initial and primary stages of treatment. Individuals who have demonstrated meaningful change and have progressed through treatment are moved to St. Peter to begin the reintegration process. In addition to the components of reintegration, St. Peter also provides alternative treatment for clients who are not appropriate for conventional programming. These clients are in need of unique treatment approaches due to developmental disabilities, traumatic brain injuries, or severe learning disabilities. As the team reviewed each option, consideration was given to the types of MSOP clients and their placement as well as the mission of each facility or proposed facility.

Section II: Background and Current Status

To accommodate the increase in psychopathic personality commitments beginning in 1991, the 1993 Legislature authorized construction of a new $20.05 million treatment facility at Moose Lake. In addition, the Legislature appropriated $8.5 million to improve security and expand capacity for psychopathic personalities at the Minnesota Security Hospital in St. Peter.

In 1995, the new 100 bed secure facility was completed in Moose Lake and named the Minnesota Sexual Psychopathic Personality Treatment Center (later to be renamed the Minnesota Sex Offender Program). By 1996, contingency beds were added on to the Minnesota Security Hospital at the St. Peter Security Hospital to address the expected increase in bed space. In 1997, with the bed space in Moose Lake nearly exhausted, the program expanded at the St. Peter campus. The 1998 legislative bonding session lead to funding for a 50 bed addition at the Moose Lake facility. In 2000, the addition was open for occupation with a total capacity of 150.

In looking at alternatives to address the growth of MSOP, the Department of Human Services proposed a collaborative project with the Department of Corrections in 2001 to provide treatment for offenders likely to be committed while they still served their prison sentence. The goal was to treat offenders prior to their release from prison to avoid additional civil commitments. DHS provides the treatment staff and DOC provides the security and treatment space. Fifty treatment beds were designated at the Minnesota Correctional Facility in Moose Lake for this unique program.

In 2003, a high profile sexual offense occurred. While no laws were changed, the system changed the practice of referrals. The interpretation of the civil commitment criteria was tightened and as a result, MSOP admissions jumped from 10-15 per year to over 50 per year, which continues today. Given this increase in admissions, by 2006, the capacities of MSOP facilities in both Moose Lake and St. Peter were reached long before anticipated and projected.

For temporary relief, MSOP rented two buildings from the Minnesota correctional facility in Moose Lake. DOC offenders were transferred to the correctional facility in Appleton and DHS paid over $3 million to renovate the prison annex into space suitable for a civil commitment program. MSOP began occupying the "the Annex" in August of 2006 and by July 2009 it housed over 200 clients. In addition to the yearly annex operating costs, MSOP paid for all DOC costs associated with renting beds from a privately owned prison and all shared security services. Over $8 million each year was paid to DOC for these costs.

In 2007, DHS began discussing the need for a major expansion of the Moose Lake facility. These discussions included adding 800 additional beds and the essential infrastructure needed for a civil commitment program including

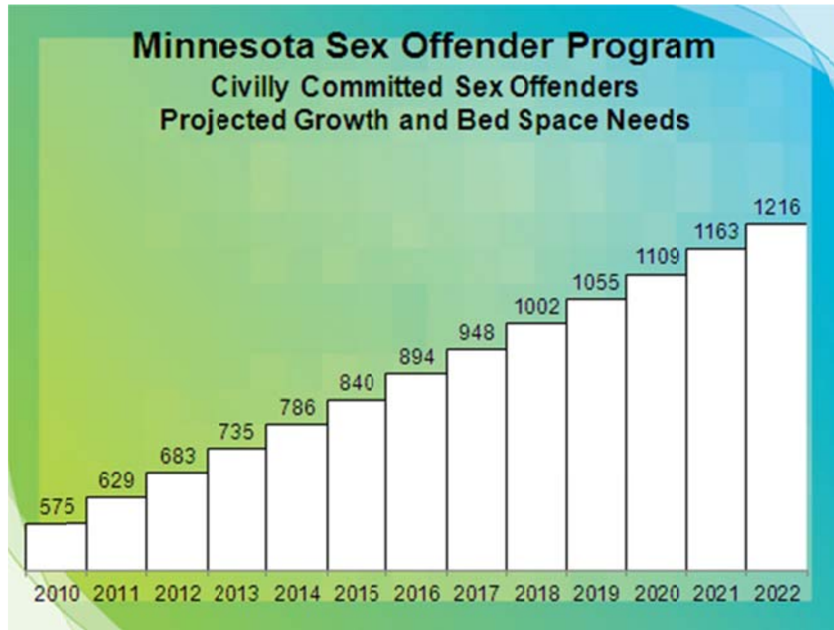
In 2008 the Legislature bonded for one 400 bed star building in Moose Lake without the essential infrastructure space. The expansion of this building opened July 2009 and immediately upon its completion, the building was at half capacity as MSOP had to move 200 clients from the DOC annex into the new building. This allowed DOC to move offenders back from the privately owned prison in Appleton into the annex and eliminated the on-going contracting costs.

In 2010, MSOP again requested bonding funding for additional essential infrastructure as well as an additional 400 bed star building. After considerable debate, the legislature funded MSOP for $47.5 million that is being used to build the essential infrastructure space for the current capacity of 550 clients in Moose Lake.

Section III: Projections and Bed Space

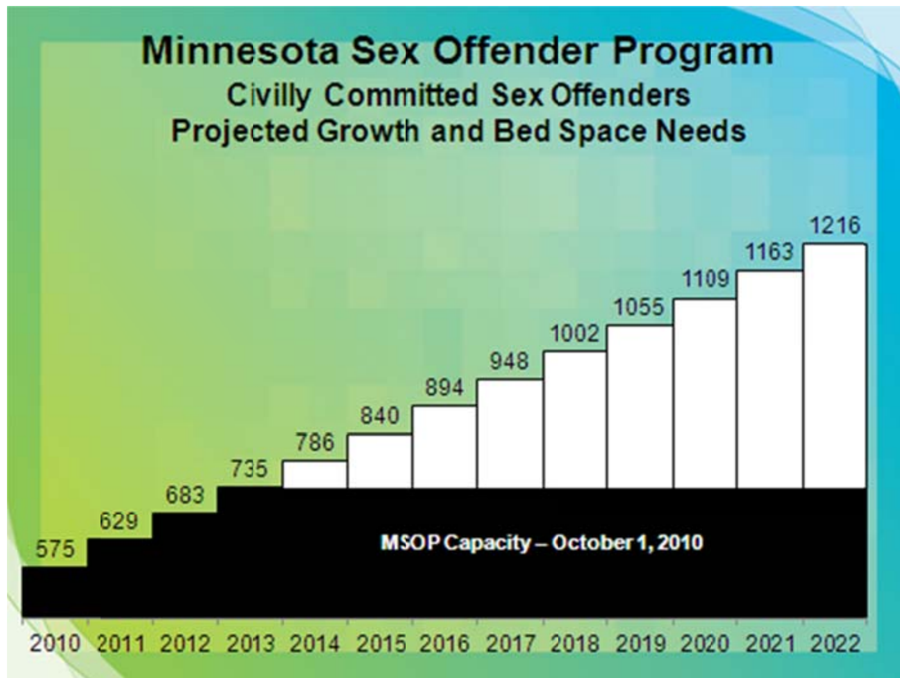
Current MSOP Projections

Given current laws, trends, and practices, preliminary projections indicate a steady annual increase of approximately 50 additional clients each year for the next several years. Subsequently, MSOP will reach capacity in both Moose Lake and St. Peter by the beginning of 2013.



Current Bed Space

The current capacities at Moose Lake (550 clients) and St. Peter (197 clients) is expected to be full by the beginning of 2013. Given it takes 18-24 months to build/renovate, MSOP would need to begin renovating space or constructing buildings in 2011 to ensure additional bed space if available in 2013.

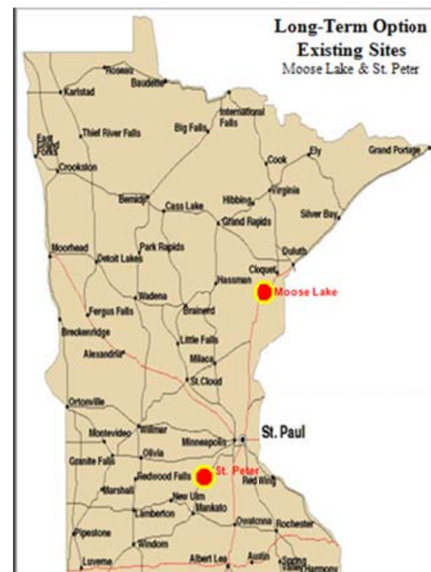


Based on the next legislative bonding cycle and the anticipated need for additional MSOP beds, short-term and long-term needs to ensure adequate space for the program is at the forefront. The

estimated construction time for 200 - 400 beds is approximately 18-24 months. Should money be allotted to do so during the next legislative bonding session (2012), construction would not be completed until July of 2014. Given current projections, MSOP will be over-capacity by 50+ beds before this construction would be completed and the beds available to MSOP clients.

As a result, MSOP will need to add approximately 50 beds by July 2013 which may lead to an emergency bonding request during the 2011 legislative session. The additional 50 beds will accommodate one more year of projected program growth allowing MSOP to make a capital bonding request during the next bonding cycle. This request will need to add 200 or 400 additional beds by July 2014 if current laws, trends, and practices continue at the current rate.

The options proposed below focus on the larger units which are more efficient. MSOP now has operational experiences with housing units ranging from 25 to 98 beds which provide great operational efficiencies and savings operating a 98 bed units compared to a smaller 25 bed unit. A stand-alone 25 bed unit will cost more to build.



Section IV: Summary of Options

Short-Term Option

St. Peter – Shantz Building Renovation: Two additional units of approximately 25 beds each would be available in the Shantz building on the St. Peter Campus. These two units are currently being used by the Minnesota Security Hospital and would have to be vacated to accommodate MSOP clients.

ADVANTAGES

- Provides 55 beds with minimal costs
- Within the MSOP secure perimeter
- Within a building currently occupied by MSOP
- Existing MSOP administration
- Existing MSOP program support

DISADVANTAGES

- Two units are currently occupied by MSH clients
- Shantz Building (circa 1960) needs asset preservation dollars

Long-Term Options

Existing MSOP Sites

Adding beds to existing sites allows MSOP to take advantage of the current support infrastructure (dinning, vocational work space, and physical plant space), core security personnel, and an existing administration.

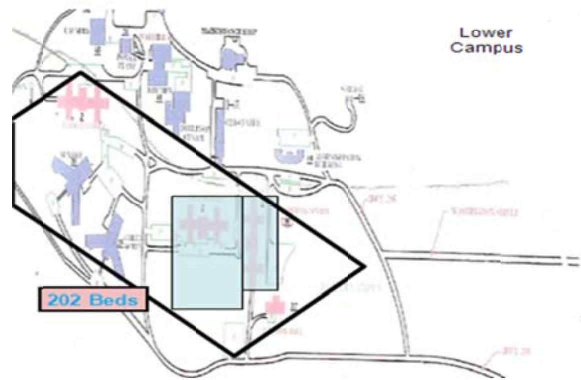
Moose Lake New Building Construction: An additional 400 bed living unit was included in the original design of the MSOP Moose Lake facility. These beds could be built in increments of approximately 200. The first addition would be two 98 bed units, which would increase the capacity by 196. The second addition would be three 68 bed units increasing the capacity by another 204. These combined expansions would increase the Moose Lake overall capacity from 550 to 950 beds.

ADVANTAGES

- A 400 bed expansion has already been designed by the architect's office
- The Phase II Housing Support building, currently under construction, was designed to meet the necessary program and support spaces required for an additional 400 bed living unit
- The secure perimeter will already be in place at the conclusion of Phase II construction
- The existing design can be bifurcated into two separate construction projects (196 bed and 204 bed additions)
- The design is more efficient for per diem reduction
- All administrative spaces and positions are in place
- Trained staff in all classifications are already on site, making for the most efficient staffing expansion
- Plant Operations mechanical and electrical systems are designed and in place to meet the needs of an additional 400 beds

DISADVANTAGES

- Requires an installation of an expanded sewer pipe
- Redesign of Health Services area would be required



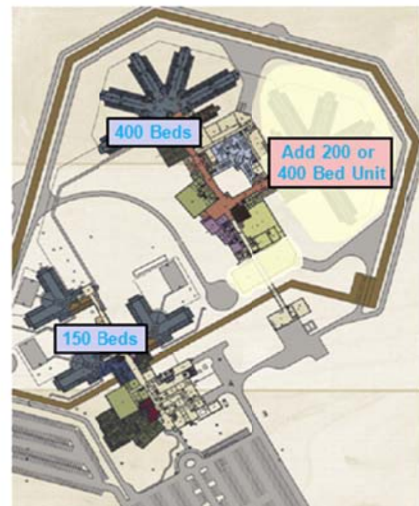
St. Peter – Bartlett/Johnson/Sunrise Renovation: There are additional buildings on the St. Peter lower campus that are currently being used by Minnesota Security Hospital for specialized populations. This would increase the capacity by 202.

ADVANTAGES

- Administrative positions are in place
- All buildings are covered by an Area Monitoring System
- Infrastructure is in place
- All buildings are located on the lower campus, adjacent to current MSOP buildings

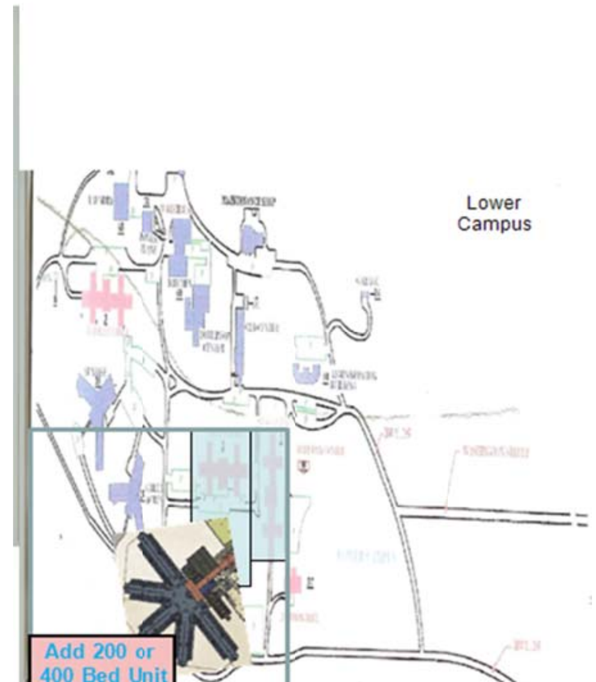
DISADVANTAGES

- Currently occupied by MSH clients
- Requires significant security enhancements
- All are older buildings requiring remodeling and asset preservation



St. Peter – New Building Construction: The St. Peter lower campus has several acres of open space. A 400 bed star

building could be built on the campus which would require considerable extension of the secure perimeter fence. This would increase the St. Peter capacity from 197 to 597.



ADVANTAGES

- Administrative positions are in place
- Activity Building to accommodate an additional 400 clients is in place
- The existing dining hall could be expanded
- St. Peter community would welcome expansion

DISADVANTAGES

- Requires significant security enhancements
- Requires significant additional program and support spaces (high security area, vocational work spaces, education areas, treatment spaces, etc.)
- Requires further "mixing" of the current client treatment stages
- Current boiler is low pressure steam. Currently piping in the tunnels will not support another building of this size, requiring a new stand-alone boiler

Existing State Sites

The State of Minnesota has several buildings that are currently on the Department of Administration's "Unused Building" list. The majority of vacant buildings on the list are not suitable for developing another campus for MSOP given many are vacant warehouses or office spaces and do not have the space needed to develop an MSOP campus. Other issues include travel and distance and significant security upgrades.

Brainerd – Renovation and Construction: One of the options discussed during the last legislative session was for MSOP to take over the majority of the State Operated Services Brainerd campus which was vacated when they down-sized services statewide. Brainerd has a total of 14 buildings on campus, of which four are currently being used by other state and county programs. Eight of these buildings could be used for 25 bed units.

ADVANTAGES

- Existing facility and buildings with room to meet MSOP expansion needs
- Would create additional jobs in Greater Minnesota
- Some physical plant infrastructure is in place

DISADVANTAGES:

- Need to relocate existing DHS specialty programs
- The facility would require the installation of an entire security system
- Creating a third MSOP site creates additional administrative costs

- Erosion of treatment design/implementation practices across multiple sites
- Distance and travel are significant issues
- Duplication of program infrastructure and functions
- Issues related to separation of client populations
- Buildings would require extensive renovation to meet current codes
- Client Housing Buildings are small and not efficient for staffing and per diems
- Licensing review would be extensive

Moose Lake Prison/Appleton – Renovation and Construction: Several proposals were introduced in the 2010 legislative session for MSOP to take over all or part of the Moose Lake prison. This would require the Minnesota Department of Corrections to develop a contract with the private prison in Appleton, Minnesota. MSOP and DOC reviewed options to add 200 or 400 MSOP clients within the secure perimeter of the Moose Lake prison. During the time MSOP and DOC reviewed this option, the private prison in Appleton, Minnesota announced they are reopening the facility at full capacity with a contract with California.

ADVANTAGES

- The Moose Lake Corrections Facility is located adjacent to MSOP
- Infrastructure is in place

DISADVANTAGES

- The Moose Lake Medium Custody Corrections Facility was constructed in 1937 with resultant dated mechanical systems
- Construction costs over the lifetime of a new building (75 years), is roughly 5% compared to the overall operational costs. Costs of the magnitude required must be carefully weighed against the overall life and condition of the existing facility
- The existing perimeter of the Moose Lake Corrections Facility has very little room for any expansion, given public housing, surrounding wetlands, and it's position adjacent to Moosehead Lake
- The Moose Lake Corrections Facility is a much larger space than is needed for the MSOP expansion
- Returning to the prior space occupied by MSOP (200 beds) is not sufficient to meet long-term MSOP needs
- Expanding MSOP at the Moose Lake Corrections Facility will result in lost efficiencies of scale in security, staffing, client program space, staff support, and client housing
- Long-term growth space at the Moose Lake Corrections Facility would require client placement in multi-level units
- Carving out sufficient growth space within the Corrections Facility requires a major restructuring of the entire Moose Lake Corrections Facility
- Meeting the space needs of the MSOP requires the DOC to look at other bed options for their population
- While close in location, this option creates another site location for MSOP
- A renovation to create two separate programs and client/offender separation is daunting
- An extensive study would be required
- MSOP has shared space at the Moose Lake Corrections Facility in the past. This was done as a short-term solution during the construction and expansion of the MSOP. This option would not meet the long-term needs of either MSOP or the DOC

Construction and Operating Costs

Short-Term Option: 55 Beds

	Shantz St. Peter
Per Diem	**$151**
Annual Budget	$3.0 m*
10 year Annual Budget	$30.3 m
Construction/Renovation	$7.0 m

Long-Term Option: 400 Beds

	MSOP Moose Lake New Building Construction	MSOP St. Peter New Building Construction	MSOP St. Peter Building Renovation	DOC Moose Lake Co-Location	State Operated Services Brainerd Renovation
Per Diem	**$138**	**$160**	**NA**	**$273**	**$250**
Annual Budget	$20.2 m	$23.3 m	NA	$39.8 m	$36.4 m
10-year Annual Budget	$202.0 m	$233.0 m	NA	$398.0 m	$364.0 m
Construction/Renovation	$56.8 m	$83.2 m	NA	$51.7 m	$151.8 m

Long-Term Option: 200 Beds

	MSOP Moose Lake New Building Construction	MSOP St. Peter New Building Construction	MSOP St. Peter Building Renovation	DOC Moose Lake Co-Location	State Operated Services Brainerd Renovation
Per Diem	**$150**	**$184**	**$188**	**$308**	**$314**
Annual Budget	$11.0 m	$13.4 m	$13.7 m	$22.4 m	$22.9 m
10-year Annual Budget	$110.0 m	$134.0 m	$137.0 m	$224.0 m	$229.0 m
Construction/Renovation	$36.0 m	$62.4 m	$42.5 m	$38.7 m	$100.0 m

**million*

Section V: Discussion and Recommendations

Short-Term

RECOMMENDATION: Based on the review of all options, the team recommends that MSOP work with MSH to move clients out of the Shantz building on the St. Peter campus. This allows MSOP to request asset preservation funds from the Legislature and to hire contractors to complete the infrastructure renovations of the Shantz building. This will increase the capacity of MSOP by 55 additional beds, which will accommodate MSOP's bed space for one more year. This timing allows MSOP to review next year's projections and develop a bonding request for the 2012-2013 legislative sessions. The low operating costs of this recommendation will assist MSOP in lowering their overall per diem.

Long-Term

RECOMMENDATION: The lowest on-going operating cost per client is the long-term option that adds a 400 bed living unit within the original design of the MSOP Moose Lake facility. This allows MSOP to take advantage of existing support infrastructure, security perimeter and administrative staff.

The MSOP Moose Lake facility expansion also allows for building only 200 or 100 beds. The 200 bed addition would include adding only two of the five housing wings. The 100 bed option would only build one of the wings. These options will still require building the additional support infrastructure, but require less bonding dollars in the near term and still allow for the additional expansion of the other wings.

These options will require Department of Human Services to request capital bonding funds during the 2012-2013 legislative sessions.

SUMMARY OF RECOMMENDATIONS

Treatment of Sexual Offenders:

Strengthen Community-Based Treatment Resources

- Create statewide standards for all community-based treatment.
- Develop mechanisms and systems to improve coordination and continuity between treatment providers.

Review the Relationship between Treatment Processes and Civil Commitment

- Conduct a study of civil commitment decisions related to individuals who have successfully participated in prison- or community-based treatment.
- Conduct a study of treatment related disclosures.

Civil Commitment Process:

- Establish a panel of judges to hear all civil commitment petitions for sexual offenders.
- Establish stronger community network of treatment, resources and accountability for sexual offenders.
- Develop community-based housing options for sex offenders on court-ordered provisional discharge.

Perpetration Prevention of Sexual Abuse:

- Identify, assess and provide resources for children who have experienced trauma including victims of sex crimes and those who demonstrate sexual behavior problems.
- Increase and strengthen community resources available for juveniles and adults who have committed acts of sexual abuse, exploitation or violence.

Bed Space Options:

- *Short-Term:* Work with MSH to move clients out of the Shantz building on the St. Peter Campus. This will increase the capacity of MSOP by 55 additional beds, which will accommodate MSOP's bed space for one more year.
- *Long-Term:* Add a 400 bed living unit within the original design of the MSOP Moose Lake facility. The MSOP Moose Lake facility expansion also allows for building of only 200 beds, or 100 beds.