OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Civil Commitment of Sex Offenders

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MARCH 2011

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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

March 2010

Members of the Legislative Audit Commission:

Minnesota's approach to civil commitment of certain sex offenders is controversial for various reasons. Our evaluation focused on the program that confines and treats civilly committed sex offenders and the process that is used to place them in the program.

We found that the costs of the Minnesota Sex Offender Program (MSOP), which is administered by the Department of Human Services, have nearly tripled in the last six years. In addition, they are expected to grow significantly in the future, since the number of civilly committed sex offenders at MSOP facilities is expected to almost double in the next ten years. Furthermore, despite the treatment provided by MSOP, no sex offender has ever been discharged from civil commitment.

Among the 20 states with civil commitment programs, Minnesota has the highest number of civilly committed sex offenders per capita. However, we found significant inconsistencies in the commitment process, which have resulted in the commitment rate in some parts of the state being almost double that in other areas. These differences raise questions about the application of Minnesota's civil commitment criteria.

Currently, civilly committed sex offenders can only be confined and treated at two high security facilities. We recommend that MSOP develop a plan for housing some offenders—particularly certain low functioning individuals—in alternative settings. We also recommend MSOP develop a stay of commitment option appropriate for certain sex offenders. Both of these options may help mitigate MSOP's accelerating costs but still offer the necessary security to protect the public.

Our evaluation was conducted by John Yunker (evaluation manager), KJ Starr, and Justin Roskopf. The Department of Human Services, the Department of Corrections, and others cooperated fully with our evaluation. We thank them for their assistance.

Sincerely,

James Nobles
Legislative Auditor

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Summary

Major Findings:

- The number of civilly committed sex offenders in the Minnesota Sex Offender Program (MSOP) nearly quadrupled during the last decade and is expected to nearly double over the next ten years. (pp. 3-5)

- Minnesota is one of 20 states with civil commitment programs for sex offenders and, in 2010, had the highest number of civilly committed sex offenders per capita. (pp. 16-18)

- MSOP's annual cost is $120,000 per offender, or about three times the cost of incarceration in Minnesota, but close to the average for other secure treatment facilities for civilly committed sex offenders. (pp. 11, 15-17)

- The number of court commitments as a percentage of referrals from the Department of Corrections varies significantly across the state. Our statistical analysis suggests that some sex offenders being committed may have a lower risk of recidivism than others who are being released from prison. (pp. 34, 39)

- Minnesota lacks reasonable alternatives to commitment at a high security facility. Lower-cost alternatives may be appropriate for some sex offenders being considered for commitment or already residing at MSOP facilities. (pp. 42-44)

- No sex offender has been discharged from MSOP since it was created in 1994. Without releases, Minnesota is susceptible to lawsuits challenging the adequacy of the treatment program. (pp. 19, 52)

- MSOP's treatment program has experienced frequent leadership changes and significant staff vacancies, and it has struggled to maintain the type of therapeutic environment necessary for treating high-risk sex offenders. (pp. 58-61, 65-72)

- Current MSOP management has worked to address security problems and clinical deficiencies, but it still needs to increase the number of treatment hours provided, improve the therapeutic environment, and establish clearer guidelines for judging treatment progress. (pp. 60-77)

To control accelerating costs, Minnesota could develop lower-cost facilities to house some civilly committed sex offenders and create an enhanced stay of commitment option for others.

Key Recommendations:

- The Legislature should require MSOP to develop a plan for lower-cost alternative facilities to be used by certain sex offenders. The plan should also outline the changes needed to implement a stay of commitment option. (p. 45)

- The Legislature should consider a variety of other options for reducing the costs of civil commitment, including changes in the commitment process, commitment standards, and financing of commitment costs, as well as changes in sentencing policy. (pp. 46-49)

- The Department of Human Services should require MSOP to provide more treatment hours per week than are currently provided. (p. 65)

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Among the 20 states with civil commitment programs, Minnesota has the highest number of civilly committed sex offenders per capita.

Report Summary

Minnesota and 19 other states have laws allowing the courts to civilly commit dangerous sex offenders following their release from prison. In Minnesota, the Department of Corrections screens offenders scheduled for release and refers those who may be appropriate for civil commitment to county attorneys. County attorneys decide whether to file a petition for commitment with the district courts, which make the final determination on commitments. Committed sex offenders are sent to the Minnesota Sex Offender Program (MSOP), which has facilities in Moose Lake and St. Peter.

Civilly committed sex offenders retain certain civil rights, including the right to treatment. Without an adequate treatment program, Minnesota could face a legal challenge.

Minnesota's population of civilly committed sex offenders has grown significantly in the last decade and is the highest in the nation on a per capita basis.

The total number of civilly committed sex offenders in MSOP has grown from less than 30 in 1990 to 149 in 2000 and 575 in mid-2010. The 2010 figure does not include another 55 or so civilly committed sex offenders who were temporarily transferred to correctional facilities.

In 2010, Minnesota had the third highest population of civilly committed sex offenders—after California and Florida—and has the highest number in the nation on a per capita basis. It is unclear exactly why Minnesota has so many civilly committed sex offenders compared with other states. Minnesota has a lower overall incarceration rate than most states, but there are no data available to determine if Minnesota has a lower rate for sex offenders. Another possible explanation is that Minnesota's laws facilitate the civil commitment of sex offenders. Unlike most states, Minnesota does not allow jury trials for civil commitment. Minnesota also allows hearsay evidence and requires the commitment standard to be met with "clear and convincing evidence" rather than proven "beyond a reasonable doubt." Minnesota also considers offenses involving emotional harm to victims, rather than just physical harm or violence.

The largest increases in commitments, however, occurred after the Department of Corrections (DOC) changed its referral practices. From 1991 to 2003, DOC referred about 26 offenders per year to county attorneys. Following a November 2003 rape and murder by a sex offender recently released from prison, DOC began referring all offenders who might meet the legal standard for commitment. With that change in policy, the number of annual DOC referrals after 2003 grew to about six times its previous rate.

The costs of civil commitment in MSOP are high relative to incarceration and other alternatives.

The annual cost per resident in MSOP is $120,000. This cost is at least three times the cost of incarcerating an inmate at a Minnesota correctional facility. Although treatment costs play a role, the primary reason why costs are higher at MSOP facilities is security, which is the biggest spending component at both MSOP facilities and Minnesota's prisons. Overall staffing per resident is about three times higher at MSOP facilities than at Minnesota's prisons. This difference largely reflects differences in the mission and average size of the two types of facilities.

The annual cost of civil commitment programs in other states with secure facilities like MSOP ranges from about $36,000 to $180,000 per year. Minnesota's annual cost was the fifth

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highest of 12 states that responded to a recent survey.

The civil commitment program in Texas, which does not rely on the same type of facilities, has an annual cost of only about $27,000 per offender. Texas houses its committed offenders in four halfway houses specifically for this population and provides outpatient treatment. In addition, the Texas program provides close supervision and monitoring and restricts the ability of residents to travel outside the halfway houses. If offenders violate the terms of their commitment, they may receive lengthy prison sentences.

There is considerable variation in commitment practices, particularly among prosecutors.

Among Minnesota's judicial districts, commitment rates vary significantly, with the percentage of referred offenders being committed varying from 34 to 67 percent.

Commitment rates in Hennepin and Ramsey counties and northeastern Minnesota are 34 to 36 percent of DOC referrals, while the rates are 43 to 45 percent in the judicial districts immediately north and south of Hennepin and Ramsey counties. Commitment rates in judicial districts throughout the rest of the state vary from 59 to 67 percent.

Statistical analyses we conducted strongly suggest that the probability of being committed is significantly higher in most of the rest of the state than it is in Hennepin and Ramsey counties and northeastern Minnesota. These analyses take into account known differences in the recidivism risk posed by offenders considered for commitment.

The differences in commitment rates appear to be largely the result of differences in the percentage of referred cases for which county attorneys file a petition. The DOC's referral practices are unaffected by geographic difference. In addition, the variation in court commitment practices is more limited than that among prosecutors.

Minnesota lacks reasonable alternatives to commitment at a high security facility.

A major problem with Minnesota's commitment process is that it generally involves a choice between a high security facility and release from prison with no supervision, if the offender has served his entire prison sentence. Minnesota law allows for consideration of a less restrictive alternative, but there are no alternatives available. Minnesota has one private residential facility for sex offenders, but it will not take any offenders being considered for commitment.

One lower-cost alternative would be to establish group homes or halfway houses for certain civilly committed sex offenders who could be managed in such a setting. Currently, there are low functioning adult offenders at MSOP for whom the impact of the treatment program has probably been maximized. Some of these offenders are probably suitable for a group home setting that lacks the high security of an MSOP facility but retains sufficient supervision and monitoring. In addition, there may be other individuals in MSOP whose risk level has been reduced and may be suitable for a halfway house alternative such as that provided in Texas. Sufficient supervision would be needed, along with appropriate consequences if individuals do not comply with the rules.

Minnesota law currently provides for a stay of commitment option, but it is rarely used since it was designed primarily for populations other than sex offenders. That option would become more viable if the law provided for supervision by MSOP or DOC instead of a social service agency, and if the law was more explicit about the conditions

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an offender must meet to avoid revocation of a stay.

With the large influx of commitments since 2003, MSOP has struggled to provide adequate treatment and maintain a therapeutic environment, particularly at its Moose Lake facility.

Over the last eight years, MSOP's treatment program has experienced frequent leadership changes and has had a significant number of staff vacancies. In addition, it has been difficult to maintain the therapeutic environment necessary for making progress with high-risk sex offenders.

No civilly committed sex offender has ever been discharged from the Minnesota Sex Offender Program.

The problems have been particularly acute at MSOP's Moose Lake facility, which serves clients in the beginning stages of treatment. At one point last year, six of the eight clinical supervisor positions were vacant at Moose Lake. In November 2010, MSOP had 17 vacancies for nonsupervisory clinical positions, with 16 of them at Moose Lake.

The lack of adequate numbers of clinical staff has meant the number of hours of treatment provided by MSOP is generally lower than that provided by civil commitment programs in other states. In addition, the number of hours provided by MSOP is less than that provided at Minnesota correctional facilities or the only private residential facility for adult sex offenders in the state.

The treatment environment has also been adversely affected by reductions in security staff and a change in their role. In recent years, the number of security staff was cut significantly, and security counselors were no longer expected to provide therapeutic support to residents. While these changes made some sense, clinical staff have not been available in sufficient numbers to fill the void.

Current management at MSOP has taken steps to address problems at its facilities. For example, despite the reduction in security staffing, MSOP's facilities have become more secure, partly due to the adoption of clear policies for resident and employee behavior. Current management is also taking steps to fill the vacancies in its treatment program. In addition, it has implemented a treatment program that appears to be consistent with accepted "best practices" in the field. Further work will be needed to make sure the program provides clear guidelines for assessing treatment progress and is implemented consistently by the clinicians who treat offenders.

No civilly committed sex offender has ever been discharged from MSOP, although MSOP is now proposing to provisionally discharge two offenders in the next six months.

Several factors may explain why no MSOP clients have been discharged from the program. First, problems in the treatment program over the last ten years have likely affected the progress of some sex offenders. Second, while a specialized court now determines whether offenders are discharged, the previous administration issued an executive order discouraging any discharges. Finally, Minnesota has a release standard for offenders who are civilly committed that, in practice, is stricter than other states. MSOP does not support any discharges without completion of the treatment program. Most states explicitly allow for discharges if an offender no longer meets the commitment criteria.

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Introduction

Minnesota and 19 other states allow for the civil commitment of dangerous sex offenders.

Minnesota and 19 other states have laws allowing the courts to civilly commit dangerous sex offenders following the completion of their prison sentences. In most of these states, civilly committed sex offenders are placed in secure facilities that provide treatment. In a few states like Texas and, to some extent, New York, civilly committed sex offenders receive treatment while living in halfway houses or other community settings.

The major public benefit of civil commitment is increased public safety. If states use the civil commitment process appropriately, sex offenders who are most likely to reoffend are living in a secure facility and not among the general public. Furthermore, such dangerous sex offenders are not released into the community until the risk that they will reoffend is lowered through treatment or for other reasons.

While civil commitment increases public safety, confinement in a secure treatment facility is costly. In Minnesota, it costs the Department of Human Services (DHS) about $120,000 per year to house and treat a civilly committed sex offender in a secure facility. The cost is roughly three times the cost of incarcerating inmates at Minnesota's correctional facilities. The high cost of civil commitment can be worth the price if civil commitment is reserved for the most dangerous offenders and if treatment is effective in reducing the risk of recidivism for at least some offenders.

There are concerns, however, that Minnesota has built an expensive system of civil commitment and has committed some offenders who could be safely treated and supervised in a less costly community setting. The number of civilly committed sex offenders has grown dramatically over the last two decades. From 1990 to 2000, Minnesota's population of civilly committed offenders grew from less than 30 to 149. As of January 1, 2011, the number has grown to 656, including 605 at DHS facilities and 51 at Minnesota correctional facilities. In 2010, Minnesota had more civilly committed sex offenders than every state except California and Florida. In addition, Minnesota had by far the largest number of civilly committed sex offenders per capita in the country. Current projections indicate that, under current policies, significant growth is likely in the future. According to DHS, the number of civilly committed sex offenders at DHS facilities is expected to nearly double between 2010 and 2020.

In addition to concerns raised about the number of sex offenders who are civilly committed, another significant issue is the apparent ineffectiveness of treatment at DHS facilities. No sex offender has been successfully discharged from the Minnesota Sex Offender Program (MSOP) since it was created in 1994. Only one offender has ever been provisionally discharged and that offender was brought back to MSOP due to technical violations of his release conditions.

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As a result of these concerns, the Legislative Audit Commission directed the Office of the Legislative Auditor to conduct a program evaluation of the civil commitment process and the Minnesota Sex Offender Program. Our evaluation focuses on the following issues:

- **How has the population of civilly committed sex offenders grown in Minnesota? How does the size of Minnesota's population compare with those in other states?**

- **What accounts for the high costs of civil commitment? How does the average cost of civil commitment in Minnesota compare with similar facilities in other states and with other public facilities in Minnesota?**

- **Is Minnesota committing the most dangerous sex offenders? Are commitment decisions being made in a consistent manner throughout the state?**

- **Is MSOP providing appropriate treatment to civilly committed sex offenders? Why have there been no discharges from MSOP facilities?**

- **Could some of the civilly committed sex offenders be treated in the community at a lower cost, while still providing significant safeguards for the public?**

To address these questions, we conducted interviews with MSOP employees, Department of Corrections employees, prosecutors, defense attorneys, psychologists, MSOP residents, and advocates for residents. We also attended several civil commitment trials and hearings. Furthermore, we reviewed a large body of literature on the risk assessment and treatment of sex offenders.

In conducting this evaluation, we used financial data from both MSOP and the Department of Corrections (DOC). In addition, we used information on referrals from DOC and on commitments from MSOP. We reviewed a substantial number of treatment and other files on MSOP residents. We also collected information on sex offenders from DOC files on sex offenders who DOC reviewed for possible civil commitment from 2006 through 2008.

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1 Background

Minnesota law calls for the civil commitment of people with "sexual psychopathic personalities" as well as those who are "sexually dangerous persons." These types of commitments result in confinement to a secure facility operated by the Department of Human Services (DHS). The commitment is for an indeterminate time and usually follows the completion of a period of incarceration at a Minnesota correctional facility.

In this chapter, we review the growth in the number of civilly committed sex offenders in Minnesota over the last two decades, as well as the projected growth in the next decade. Furthermore, we present information on the costs of civil commitment and compare those costs to other types of state-operated residential facilities. Finally, we examine how Minnesota compares with other states in the number of civilly committed sex offenders and the average cost of confinement.

CIVIL COMMITMENT POPULATION

In this section, we discuss the growth that has occurred over the last two decades in the number of sex offenders civilly committed in Minnesota, as well as the projected growth over the next decade. We also present information on the age, race, and education level of the civilly committed population. Finally, we examine the number and type of felony convictions on the criminal records of civilly committed sex offenders.

Past Growth

The total number of civilly committed sex offenders has nearly quadrupled in the last ten years.

As of July 1, 2010, there were 575 civilly committed sex offenders at DHS facilities at Moose Lake and St. Peter. This figure does not include another 55 or so civilly committed sex offenders who were serving time at a Minnesota correctional facility. Most of these latter offenders were temporarily transferred from DHS facilities to correctional facilities to serve new criminal sentences or to serve out the remainder of a previous sentence due to violations of their supervised release conditions. These offenders will be returned to DHS following completion of their remaining prison sentence.

The 2010 figure of 575 civilly committed sex offenders is the result of significant growth in the number of commitments that occurred in both of the last two decades. Even though the Legislature first enacted the psychopathic personality commitment law in 1939, the overall number of people committed was fairly low until the 1990s. As Figure 1.1 illustrates:

- **The total number of civilly committed sex offenders has grown from less than 30 in 1990 to 149 in 2000 and 575 in 2010.**

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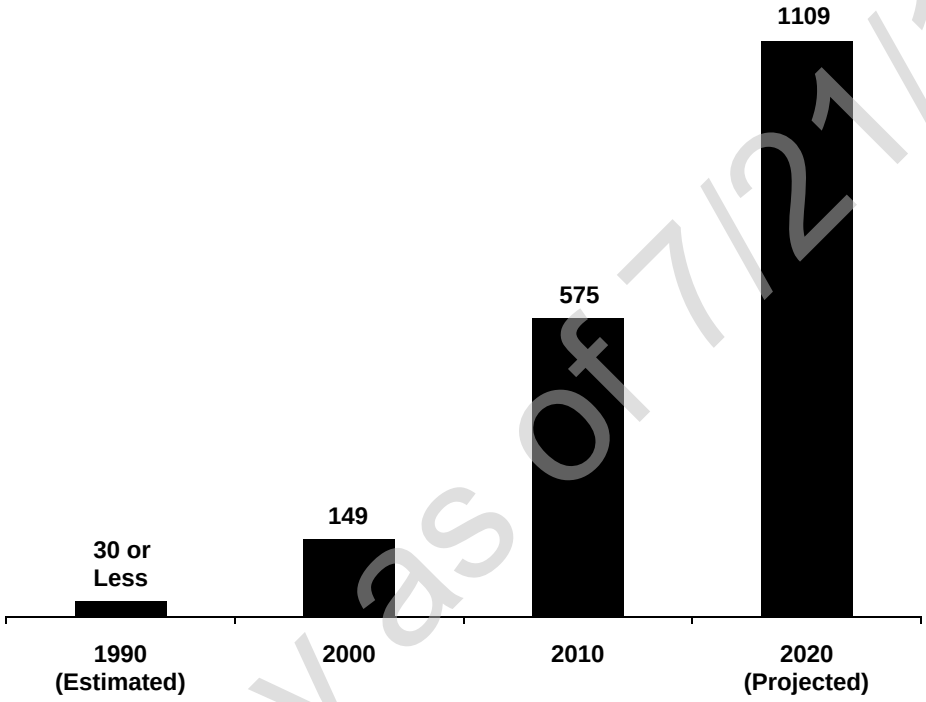
Figure 1.1: Total Number of Civilly Committed Sex Offenders in Minnesota, as of July 1 of 1990-2020



SOURCES: Minnesota Sex Offender Program, and Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, February 1994), 11.

The growth was about fivefold from 1990 to 2000. From 2000 to 2010, the civilly committed population grew 286 percent, or nearly fourfold. No civilly committed sex offenders have been successfully discharged from these DHS facilities since at least 1994 when the current program was created.[1]

Although there are a number of reasons for the growth in the number of civilly committed sex offenders, several key policy changes have facilitated that growth. In 1991, the Department of Corrections (DOC) began screening sex offenders in its custody for possible referral to county attorneys for civil commitment. Prior to that date, it was entirely up to county attorneys to identify candidates for possible commitment proceedings. This change brought more cases to the attention of county attorneys and resulted in a greater number of commitments than in the past. In part, the decision to refer sex offenders to county attorneys was a response to growing public concern about crimes committed by sex offenders. After several rapes and murders in 1987 and 1988, the Attorney General convened a task force to review current policies and practices and to prevent sexual violence against women. Among other recommendations, the task force recommended greater use of the civil commitment statute for sex offenders

[1] One sex offender was provisionally discharged but was returned to a DHS facility due to technical violations of the conditions of his release. He subsequently died while at a DHS facility.

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The largest growth in commitments came after a heinous crime in late 2003 and a subsequent change in referral practices by the Department of Corrections.

released from prison and indeterminate prison sentences for dangerous sex offenders convicted of new offenses.

Several legislative changes may also have contributed to the growth in the civilly committed sex offender population. For example, the 1994 Legislature expanded the standard for commitment by explicitly authorizing the commitment of sex offenders whose offenses involved emotional harm to victims and not just physical harm. The 1994 Legislature also allowed for the commitment of sex offenders who were likely to engage in acts of harmful sexual conduct even if they did not exhibit an utter lack of power to control their sexual impulses.

In late 2003, DOC significantly increased the number of sex offenders referred to county attorneys for possible civil commitment. Over the 12 years prior to December 2003, DOC had referred 333 sex offenders to county attorneys, or about 26 per year. In response to the rape and murder of a college student in northwestern Minnesota by an offender recently released from a Minnesota correctional facility, DOC undertook an extensive review of sex offenders in prison and the community. In December 2003, DOC referred another 236 offenders to county attorneys. From 2004 through 2008, DOC referred 786 offenders, or about 157 per year.

Most civilly committed sex offenders were admitted to DHS facilities in recent years. As of June 2010, about two-thirds of civilly committed sex offenders were first admitted to a DHS facility between 2004 and 2010.[2] About one-third were admitted from 1991 to 2003. Only 1 percent of the current population was first admitted during the earlier period when DOC was not making referrals to county attorneys.

Projected Growth

Strong growth in the civilly committed population is expected over the next decade.

DHS projects that the population of civilly committed sex offenders will continue to grow at a fast pace, although at a slower rate than in the last 20 years. The department expects about 53 new commits each year through the year 2022. Overall:

- **The number of civilly committed sex offenders is expected to nearly double in the next ten years.**

In making these projections, DHS assumes no change in current laws and practices. For example, DHS is assuming that there are no discharges from their facilities. The department is also assuming that the percentage of sex offenders committed upon release from prison does not change.

As noted above, future growth—while considerable—is expected to be at a lower rate than in the past. The number of civilly committed sex offenders doubled in five years from 2000 to 2005, and will probably double in the six years between 2005 and 2011. Another doubling is expected in the twelve years between 2011

[2] This calculation includes all civilly committed sex offenders, including those currently at DOC facilities.

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and 2023. Expected growth from 2010 to 2020 is 93 percent under current law and practices.

Demographic Characteristics

DHS maintains information on certain demographic characteristics of its civilly committed population, including sex, race, age, and number of years of formal education. As of the end of 2009, all civilly committed sex offenders were male except for one. About three-fourths of the population were white/Caucasian, while 13 percent were black/African American, 7 percent were Native American, and 3 percent were Hispanic.

As of June 2010, the civilly committed population ranged in age from 19 to 84. The average and median age of the population were both 44. About 14 percent of the population were less than 30 years old, while 24 percent were in their thirties and 28 percent were in their forties. About 20 percent were in their fifties, with 10 percent in their sixties, and 4 percent in their seventies or eighties.

About 53 percent of the offenders at DHS facilities have had 12 years of formal education, while 20 percent have had more than 12 years. Only 7 percent have had eight or fewer years of formal education. However, there are offenders whose reading and mathematics competencies have tested lower than would be expected given their years of formal education. In addition, about one-sixth of the civilly committed sex offenders are in an alternative program for low-functioning adults and generally have IQs below 80. Additional offenders with lower than average IQs or other cognitive issues are in the general population at DHS facilities.

Felony Convictions

DHS does not have an electronic database on its civilly committed population that provides information on their sex convictions, psychological diagnoses, test scores to predict the likelihood of recidivism, or other factors that were considered in their civil commitment proceedings. However, information is available from the Minnesota Sentencing Guidelines Commission (MSGC) on the felony convictions of civilly committed sex offenders who were sentenced between 1991 and 2008. In an analysis published in February 2010, MSGC staff were able to obtain records for 486 of the 556 sex offenders in the Minnesota Sex Offender Program (MSOP) as of January 2010. MSGC staff found that the average number of felony convictions for offenders whose records were obtained was 3.5, while the median number was 3. As Figure 1.2 indicates, about 13 percent of the civilly committed sex offenders had only one felony conviction, and about 20 percent had two felony convictions. About 36 percent had four or more felony convictions. The 70 individuals that MSGC staff could not match to their records include those with no felony convictions, and possibly some

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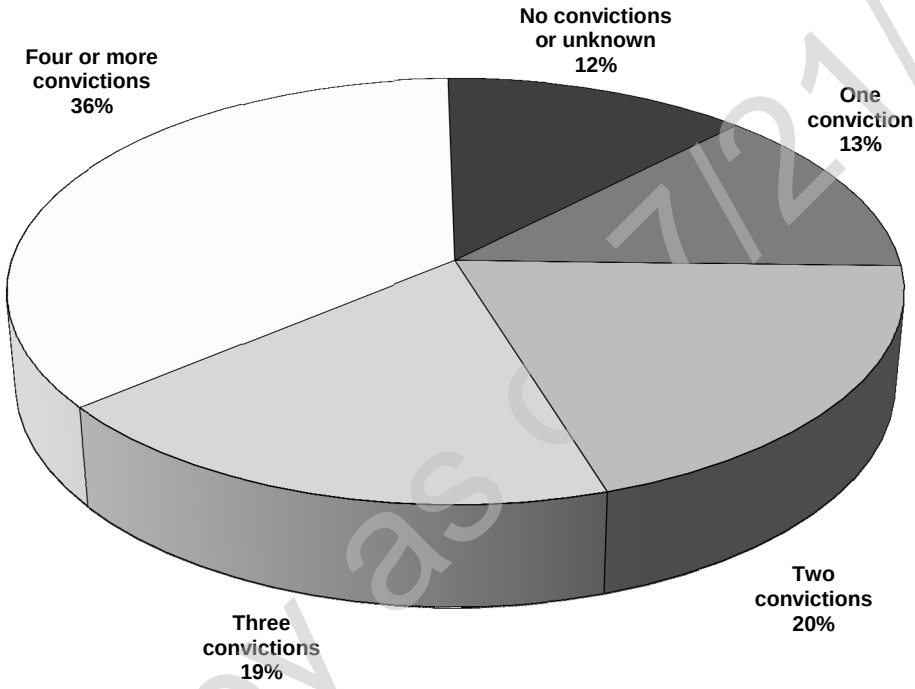
Most civilly committed sex offenders have multiple felony convictions.

Figure 1.2: Number of Felony Convictions for Civilly Committed Sex Offenders in Minnesota



NOTES: This figure includes felony convictions for sexual and other offenses for the 556 civilly committed sex offenders who were at DHS facilities in January 2010. However, Minnesota Sentencing Guidelines Commission could only find felony records for 486 of these individuals. The "no convictions or unknown" category includes individuals without a felony conviction and may also include some offenders whose only felony convictions occurred before 1991 or in other states.

SOURCE: Minnesota Sentencing Guidelines Commission, *Information on Patients Committed to MSOP* (St. Paul, February 2010).

offenders whose only felony convictions occurred prior to 1991 or in other states.[3]

Table 1.1 shows the percentage of offenders that had certain types of felony convictions. About 42 percent of the offenders had at least one conviction for first-degree criminal sexual conduct, while 46 percent had at least one conviction for second-degree criminal sexual conduct. The analysis from MSGC staff also includes felony convictions for nonsexual offenses. About 29 percent of

[3] MSGC staff had records on offenders sentenced between 1991 and 2008. They were able to match 424 offenders in MSOP with MSGC records, and got information on the records of 62 additional offenders from DOC microfilm. However, they could not find felony conviction records for 70 of the individuals in MSOP. This group includes: (1) individuals who did not have a felony conviction; (2) individuals whose only felony convictions were in other states; and (3) individuals whose only felony convictions occurred prior to 1991, but whose records could not be located using DOC microfilm.

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Table 1.1: Type of Felony Convictions of Civilly Committed Sex Offenders

Offense Type	Percentage of Offenders with at Least One of These Convictions
First-Degree Criminal Sexual Conduct	42%
Second-Degree Criminal Sexual Conduct	46
Third-Degree Criminal Sexual Conduct	29
Fourth-Degree Criminal Sexual Conduct	19
Criminal Sexual Conduct Unknown Degree	7
Failure to Register as a Sex Offender[a]	5
Child Pornography[b]	2
Other Sex Offense[c]	4
Offense Against a Person (Other than a Sex Offense)	28
Property Offense	29
Drug Offense	6
Other Offense	6
Juvenile Sex Offense[d]	8
Misdemeanor Sex Offense[d]	11

NOTES: The percentages in this table are based on the 486 civilly committed sex offenders whose records could be matched by the Minnesota Sentencing Guidelines Commission. Another 70 civilly committed offenders who were at DHS facilities in January 2010 could not be matched to MSGC records. This latter group of offenders includes those without a felony conviction and those whose only felony convictions were prior to 1991.

[a] This offense has only been a felony for a first offense since 2000.

[b] This offense has been in effect in its current form since 2001.

[c] "Other Sex Offense" includes: felony fifth-degree criminal sexual conduct or indecent exposure, solicitation of children to engage in sexual conduct, or use of minors in sexual performance.

[d] Information on juvenile and misdemeanor sex offenses may not be complete.

SOURCE: Minnesota Sentencing Guidelines Commission, *Information on Patients Committed to MSOP* (St. Paul, February 2010).

offenders had a conviction for a property offense, and 6 percent had a drug conviction.

Many civilly committed sex offenders have more offenses and victims than convictions.

However, many sex offenders have a greater number of sexual offenses and victims than is represented by their number of felony convictions. In 2010, MSOP collected information on a random sample of 50 MSOP residents. For these 50 residents, the median number of sexual crime convictions was two, but the median number of victims per resident was 11.5. The lowest number of victims for any of the 50 residents was three. The number of sexual offenses tends to exceed the number of convictions because many sex crimes are unreported and some reported crimes do not result in convictions. However, because the sample of residents was small, it is unclear how many MSOP residents have a low number of victims, as well as a low number of convictions.

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About 3 percent of registered sex offenders are civilly committed.

It should be noted that the sex offenders at MSOP represent a relatively small percentage of all registered sex offenders.[4] MSOP has estimated that 3 percent of registered sex offenders are at MSOP facilities and 16 percent are at correctional facilities. But 81 percent of registered sex offenders are living in the community on probation or a form of supervised release.

If the civil commitment process works appropriately, civilly committed sex offenders in MSOP are those who are assessed to be more likely than most other sex offenders to commit sexual offenses if they were living in the community. Civilly committed sex offenders must be "highly likely" to commit harmful sexual offenses in the future. In contrast, a 2007 study by the Minnesota Department of Corrections found that, among all sex offenders released from Minnesota correctional facilities between 1990 and 2002, only 10 percent were reconvicted of a sexual offense and 7 percent were reincarcerated within an average period of 8.4 years.[5] The study also found that the sexual recidivism rate for sex offenders released from Minnesota correctional facilities has declined significantly. Reconviction rates three years after release from prison declined from 19 percent for those released in 1990 to 3 percent for those released in 2002. The report attributes the decline in sexual recidivism rates to longer and more intensive post-release supervision of sex offenders.

DHS FACILITIES

DHS has facilities for housing and treating civilly committed sex offenders in both St. Peter and Moose Lake. The program started at St. Peter on the grounds of the state hospital. Remodeled facilities at St. Peter now provide a licensed capacity of about 197 beds and primarily house sex offenders in the most advanced stages of treatment and sex offenders who are also low functioning in their cognitive abilities.

A new facility was constructed in 1995 at Moose Lake and subsequently expanded several times. The facility has a current licensed capacity of 550 beds and houses newly admitted sex offenders, individuals in the first two stages of treatment, and those who refuse treatment. The facility is currently being expanded and remodeled to provide programming and other space that was not included when the last addition of 400 beds was completed.[6] No additional beds are being built as part of the current expansion.

[4] In Minnesota, certain sex offenders must provide their name, address, and other information to authorities. The registration database is maintained by the Minnesota Bureau of Criminal Apprehension. See *Minnesota Statutes* 2010, 243.166.

[5] Minnesota Department of Corrections, *Sex Offender Recidivism in Minnesota* (St. Paul, April 2007).

[6] The 2010 Legislature appropriated $47.5 million for the current project in Moose Lake.

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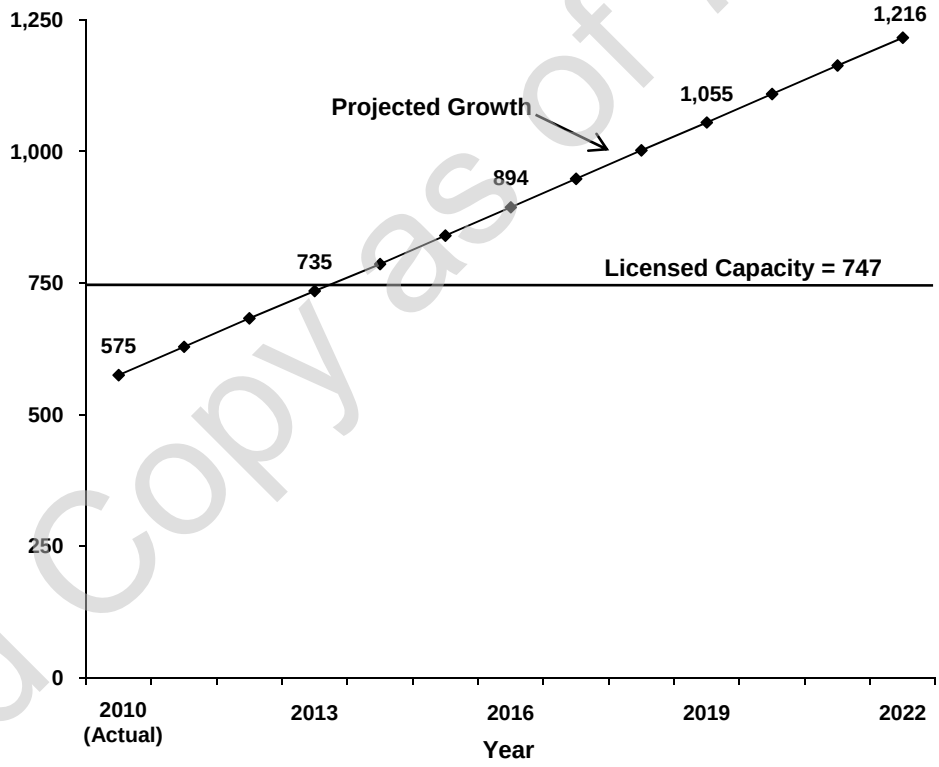
Overall, the DHS facilities for civilly committed sex offenders have a licensed capacity of about 747 beds.[7] However, as discussed earlier, DHS expects there to be strong continued growth in new commitments. As Figure 1.3 shows:

- **The number of civilly committed sex offenders under DHS control is expected to exceed the existing capacity at St. Peter and Moose Lake beginning sometime in 2013.**

State facilities for civilly committed sex offenders are expected to be at capacity in about two years.

Figure 1.3: Projected Growth in Civilly Committed Sex Offenders and Existing Bed Capacity, 2010-22



NOTE: The number of civilly committed sex offenders is projected for July 1 of each year.

SOURCE: Minnesota Sex Offender Program.

[7] In addition to its 550 licensed beds, the Moose Lake facility has an additional 26 high security beds that are used if residents exhibit disruptive behavior. The St. Peter facility does not have any additional beds specifically for this purpose. As a result, DHS officials consider the effective operating capacity at St. Peter to be about 188 beds for planning purposes, or nine beds less than the 197-bed licensed capacity. The nine beds provide a cushion in case there are behavioral issues or problems with incompatibility between roommates.

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DHS has developed options to meet the immediate and long-term bed space needs. These options were presented in a January 2011 report that was mandated by the 2010 Legislature.[8]

The facilities at St. Peter and Moose Lake are managed by the Minnesota Sex Offender Program (MSOP), which is part of the Department of Human Services. Prior to 2008, MSOP was part of the State Operated Services (SOS) Division within DHS.[9] Some of its staff and management had shared responsibilities within both MSOP and the SOS Division. However, beginning in 2008, DHS hired a new management team for MSOP and separated their functions and staff from SOS. MSOP also began reporting directly to the commissioner of human services rather than to the management of SOS.

In addition to its responsibility to operate the facilities at St. Peter and Moose Lake, MSOP operates a sex offender treatment program at the Moose Lake Correctional Facility. MSOP currently has about 10 staff assigned to that program. From 2001 through 2009, about 236 men have been admitted to the program. The primary purpose of the program is to provide treatment to sex offenders who are likely candidates for civil commitment upon their release from prison. The goals of treatment are to reduce the number of offenders who are civilly committed and to reduce the length of stay at MSOP facilities for those who are subsequently committed.

COSTS OF CIVIL COMMITMENT

The public costs of civil commitment include MSOP's costs of operating facilities, the Department of Corrections' costs of screening offenders, prosecuting attorneys' costs of petitioning courts for civil commitment, and the district courts' costs of reviewing and deciding civil commitment cases. Our focus in this report is on the costs of operating MSOP facilities. The lack of centralized information on prosecution and court costs necessitates that focus.

MSOP Costs

The Minnesota Sex Offender Program (MSOP) costs about $120,000 per resident annually.

The costs of operating MSOP are significant on a per resident basis.

- **For fiscal years 2010 and 2011, the Minnesota Sex Offender Program had an estimated per diem cost of $328, or about $120,000 per resident annually.**

As required by law, these estimates are based on legislative appropriations and projected average daily counts of residents. The spending figures include

[8] Department of Human Services, *Options for Managing the Growth and Cost of the Minnesota Sex Offender Program: Facility Study* (St. Paul, January 2011). The report was required under *Minnesota Laws* 2010, chapter 189, sec. 18, subd. 6. The DHS report also includes a review of current civil commitment policies, sex offender treatment programs, and sex abuse prevention efforts.

[9] State Operated Services consists of an array of programs and facilities serving people with mental illness, developmental disabilities, chemical dependency, and traumatic brain injury.

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operating expenditures, which were estimated to be $64.8 million in fiscal year 2010, and various indirect costs such as bond interest and building and capital asset depreciation, which were estimated to be $5.2 million.[10]

Actual operating expenditures for fiscal year 2010 were $58.8 million. In addition, facility population numbers were lower than projected earlier. As a result, the actual per diem cost for fiscal year 2010, including indirect costs, was about $320, or about $117,000 per resident annually. Based on the most recent projections of the number of residents, the per diem cost will be $333 (or $122,000 per resident) in fiscal year 2011, if MSOP spends its entire current operating budget of $67.5 million for fiscal year 2011.[11]

MSOP Operating Expenditures

In the last six years, MSOP's operating expenditures have nearly tripled.

MSOP operating expenditures have grown significantly over the last six years, in large part due to the increase in the number of residents in MSOP. Between fiscal years 2004 and 2010, spending grew from $20.4 million to $58.8 million, while the average population at MSOP facilities increased from 217 to 548. Future spending growth is expected due to the projected growth in the civilly committed population. However, MSOP believes that additional residents can be accommodated at a lower marginal cost than the current average per diem cost of $328, particularly if they are housed in new or remodeled facilities at the existing locations in Moose Lake and St. Peter. If so, the addition of residents will bring down the overall average per diem cost.

MSOP's operating expenditures are now lower than the peak of $75.0 million in fiscal year 2008. When a new management team was hired beginning in 2008, they were faced with a budget deficit. In response, management significantly reduced staff positions, particularly in the security area. Another significant part of the budget reductions since fiscal year 2008 was facilitated by the opening of a 400-bed building at Moose Lake in July 2009. MSOP had been spending about $8 million annually to rent bed space and other services at the Moose Lake Correctional Facility from the Department of Corrections. The opening of the new MSOP building eliminated the need to rent DOC space.

The biggest portion of MSOP spending is for security. Table 1.2 shows that about 45 percent of operating expenditures in fiscal year 2010 were for security. About 19 percent of expenditures were for administration and support services. This category not only includes salaries and benefits for MSOP administrative and support service staff, but also includes the costs of services provided by the Department of Human Services to MSOP, as well as equipment costs that are not allocated to other areas.

[10] For fiscal year 2011, MSOP used an operating budget of $67.5 million and indirect costs of $5.7 million to estimate its per diem costs.

[11] Because of a carryover of funds from fiscal year 2010, MSOP had a spending authority of about $73.5 million for fiscal year 2011. However, MSOP has allocated $2.4 million for capital projects that will help increase the capacity of its St. Peter facility. In addition, as a result of an executive order, MSOP is expected to reduce its fiscal year 2011 spending authority by about $3 million.

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In fiscal year 2010, about 45 percent of MSOP's operating expenditures were for security, while only 12 percent were for sex offender treatment.

Table 1.2: Minnesota Sex Offender Program Operating Expenditures and Staffing, by Type, FY 2010

Function	Percentage of Operating Expenditures	Percentage of Staffing
Security	45%	61%
Administrative and Support Services[a]	19	11
MSOP Clinical Treatment	11	11
Health Care	8	6
Physical Plant	8	3
Dietary	3	1
Vocational	3	2
Recreational	2	2
Educational	1	1
DOC Clinical Treatment	1	1
Total	100%	100%

[a] Expenditures include transfers to the Department of Human Services for services provided to the Minnesota Sex Offender Program.

SOURCE: Minnesota Sex Offender Program.

The clinical treatment program at MSOP accounted for only about 11 percent of operating expenditures in fiscal year 2010.[12] In addition, the clinical treatment provided by MSOP at the Moose Lake Correctional Facility accounted for a little more than 1 percent of MSOP's fiscal year 2010 spending.

MSOP Staffing

The biggest component of MSOP's operating budget is salaries and benefits for MSOP staff. In fiscal year 2010, about 83 percent of operating expenditures were for the salaries and benefits paid to MSOP staff. Salaries and benefits accounted for a somewhat lower share of spending (72 percent) in the previous two fiscal years, largely due to the rent paid to DOC during those years.

In fiscal year 2010, MSOP had 714 full-time equivalent staff while it averaged about 548 residents.[13] In other words:

- **During fiscal year 2010, the Minnesota Sex Offender Program had about 1.3 staff per resident.**

[12] For fiscal year 2011, the clinical treatment program at MSOP is expected to account for 11 to 12 percent of operating expenditures. The percentage was slightly lower in fiscal year 2010 due to a significant number of vacant clinical positions, particularly at MSOP's Moose Lake facility. We discuss clinical staffing and vacancies in more detail in Chapter 3.

[13] The calculation of full-time equivalent staff is based on the number of hours of work and paid leave that actually occurred during fiscal year 2010. The total number of such hours is then divided by 2088 hours to calculate the number of full-time equivalent staff. We did not include overtime hours or shift differential pay when calculating the number of full-time equivalent staff.

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The number of MSOP staff has declined over the last three years, primarily due to reductions in the number of security staff. The number of staff positions declined from 1,029 in January 2008 to 731 in January 2010 due to the budget cuts made in order to bring the budget in line with legislative appropriations.[14] For fiscal year 2011, MSOP's budget includes funding for 722 positions.

As Table 1.2 indicates:

- **A majority of MSOP staff provides security at MSOP's facilities.**

In fiscal year 2010, 61 percent of the full-time equivalent staff at MSOP was security staff, while 11 percent were clinical treatment staff serving MSOP clients. Another 11 percent of staff performed administrative or support services functions. Six percent of MSOP staff provided health care services.

Cost Sharing

The state pays 90 percent of MSOP's costs, and counties pay the remaining 10 percent.

Not all of MSOP's costs are ultimately paid by the state. Specifically:

- **For civilly committed sex offenders, the state pays 90 percent of MSOP's estimated per diem cost and recovers 10 percent from counties.**

This share of costs is recovered from the county with financial responsibility, as defined in *Minnesota Statutes* 2010, 246B.01, subd. 1b, and deposited in the state's General Fund. About 95 percent of the time, the county with financial responsibility is the county which filed the commitment petition for an offender.

In some cases, offenders finish serving their prison sentences before their commitment cases have been completed. The courts may order these offenders to be held at a secure facility pending the outcome of the commitment case. The offenders may be held at an MSOP facility, a Department of Corrections facility, or a county jail during that time. If an offender is held at an MSOP facility, the responsible county pays the entire cost of confinement. If an offender is held at a DOC facility or a county jail on a judicial hold, the county and the state each pay 50 percent of the costs.

For any committed offender residing at an MSOP facility during either fiscal year 2010 and 2011, a county's responsibility is $32.80 per day. For any offender held at an MSOP facility prior to commitment, the county is responsible for the full $328 per diem cost.

Comparisons with Other Institutions

We compared the costs of operating MSOP facilities with the costs of certain other state-run residential facilities. In particular, we examined the costs of

[14] The number of staff positions is roughly equivalent to the number of full-time equivalent staff at a particular point in time.

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operating Minnesota's state correctional facilities and the per diem rates charged at various Department of Human Services facilities. We found that:

- **The cost per resident at Minnesota Sex Offender Program facilities is considerably more than the cost at Minnesota correctional facilities but significantly less than the cost at other Department of Human Services facilities.**

MSOP's per diem cost is about triple the cost at Minnesota's correctional facilities, with much of the difference due to higher staffing ratios at MSOP facilities.

In comparing MSOP's per diem cost with Minnesota correctional facilities, we excluded any capital-related expenditures.[15] For fiscal year 2010, the average cost at a Minnesota correctional facility was about $97 per day, or about $35,000 per year. This figure includes health care and treatment costs, as well as institutional support services and 65 percent of operational support costs.[16] Since this correctional facility per diem cost does not include depreciation or bond interest, those costs should be excluded from MSOP costs in order to make a fair comparison. The comparable actual MSOP per diem cost was about $296 in fiscal year 2010. In other words:

- **The cost per resident at Minnesota Sex Offender Program facilities is about three times the average cost of incarceration at Minnesota correctional facilities.**

The main reason for this difference is that MSOP facilities have a staffing ratio that is a little more than three times that at Minnesota's correctional facilities. In fiscal year 2010, MSOP facilities had 1.3 staff per resident, while DOC facilities had a ratio of 0.4 staff per inmate in fiscal year 2009.[17] Average salaries at MSOP facilities were about 8 percent lower than at DOC facilities, but that difference only offset a small portion of the cost difference caused by MSOP's higher staffing ratio.[18]

Much of the difference in staffing ratios can be attributed to differences in security staff, since security accounts for a large portion of the staff complement of both agencies. DOC facilities can have lower security staffing ratios than

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[15] We excluded capital costs because MSOP and DOC are required to calculate capital costs in different ways when computing per diem rates. MSOP includes bond interest and depreciation in its per diem rates, while DOC includes the actual repair, equipment, and capital costs that are incurred in a particular year in its "statutory" per diem.

[16] Operational support includes the central office functions of the Department of Corrections that support both its correctional facilities and its probation function. The 65 percent allocation of operational support costs to correctional facilities has been used in the past as a rough indication of the share of these costs that can be attributed to support for correctional facilities. The per diem figure we used for correctional facilities exceeds the facility operating cost per diem that DOC publishes due to the inclusion of these support costs, as well as health care and behavioral health costs. Our figure is equivalent to DOC's "statutory per diem" minus capital costs.

[17] The DOC figure includes staff at the correctional facilities, as well as institutional support services staff and 65 percent of operations support services staff.

[18] In fiscal year 2010, MSOP security salaries and other pay were about 10 percent lower than DOC security salaries and other pay. Average salaries for other staff were about 3 percent lower at MSOP than DOC. Some of the differences, particularly in the security area, can probably be attributed to the fact that MSOP staff have less tenure in their jobs than their DOC counterparts. As a result, DOC staff are probably at higher steps in their pay ranges.

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MSOP facilities because DOC facilities are generally much larger than MSOP facilities. Five of DOC's facilities have an average population ranging from close to 1,000 to over 1,500. Lower security ratios are possible in correctional facilities with large cell blocks.[19] In addition, lower security ratios are possible there because resident movement can be more restricted than it can be in a facility for civilly committed individuals.

MSOP also has higher staffing ratios for treatment staff than does DOC. However, the differences in treatment staff do not play a large role in explaining the overall difference in staffing ratios, since treatment staff account for a relatively small share of MSOP's overall staff complement.

In contrast, MSOP's per diem rate of $328 is much lower than those at other DHS residential facilities. As of August 1, 2010, DHS set per diem rates for mental health services that varied from $982 at the Anoka-Metro Regional Treatment Center to $1,484 for child and adolescent behavioral health services. Per diem rates for forensic services ranged from $425 for transition services to $618 at the Minnesota Security Hospital. We did not examine the underlying cost components for these services, but we suspect that these services involve greater staffing ratios than at MSOP facilities. They may also involve greater numbers of higher paid medical or psychiatric staff than employed at MSOP facilities.

OTHER STATES

Nearly all the states with civil commitment programs use secure treatment facilities for all their residents, except Texas and New York.

Minnesota is one of 20 states with civil commitment programs for sex offenders.[20] Civil commitment programs are scattered throughout the nation, but they are more common among the states with higher populations. Fourteen of the 22 states with populations exceeding five million have civil commitment programs for sex offenders. About 63 percent of the nation's population lives in states with civil commitment programs.

Nearly all of the programs confine the civilly committed population in secure facilities. However, the program in Texas is exclusively an outpatient program. The civilly committed population primarily lives under GPS surveillance in halfway houses in four locations throughout Texas. Activities of the offenders outside of the halfway house are greatly restricted. Violations of the conditions of commitment—including failure to participate in treatment—are a felony in Texas and may result in a lengthy prison sentence. However, according to those

[19] We estimated the staffing ratio for the high security correctional facility in Oak Park Heights to be about 0.67 staff per inmate in fiscal year 2009, including a prorated share of institutional support staff and operations support staff. This facility had an average inmate population of 436 in fiscal year 2009 and is much smaller than most other DOC facilities. This suggests that, even within DOC, staffing ratios are affected by the size and function of the facilities.

[20] In addition to Minnesota, the states with civil commitment programs include California, Florida, New Jersey, Illinois, Wisconsin, Massachusetts, Washington, Virginia, New York, Kansas, Texas, Missouri, Nebraska, South Carolina, Arizona, Iowa, North Dakota, Pennsylvania, and New Hampshire. The program in Pennsylvania is only for juvenile offenders, while programs in other states are primarily for adult offenders. The federal government also has a civil commitment program for adult sex offenders.

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managing the Texas program, no civilly committed sex offender has been charged or convicted of a new sex offense.

The program in New York is unique in that it has two tracks. Some offenders are committed to a secure facility, while others are managed in the community using intensive supervision. In both settings, civilly committed offenders receive treatment. Those committed to intensive supervision can be revoked for violations and re-petitioned for commitment to a secure facility. One drawback of the New York program is that it does not provide housing for the offenders, and many of them have unstable housing situations. In New York, two persons on intensive supervision have been convicted of sexual touching.

MSOP's per diem cost is close to the average for other states with high security facilities for civilly committed sex offenders.

Costs per Resident

In most states, civil commitment programs are fairly expensive and generally cost more than incarcerating inmates at a prison. Based on available information, it appears that:

- **Minnesota's per diem cost for civilly committing sex offenders is higher than the cost in some states but lower than that in other states.**

Minnesota's per diem rate of $328 was the fifth highest of 12 states that responded to a survey conducted by MSOP staff.[21] The comparison was based on the reported budget and number of clients as of June 30, 2009. Per diem costs ranged from $98 to $493. The median cost was $284 per day, while the average was $295 per day. Although Minnesota's published per diem was about 11 percent above the average, its actual per diem ($296) without depreciation and bond interest costs was close to the average. Because most of the states responding to the survey did not include these expenses in their per diem costs, it is appropriate to conclude that MSOP's costs per resident are about average for this group of states.

Costs in Texas are significantly lower because it does not use high security facilities.

Texas was not included in the survey conducted by MSOP staff because, unlike programs in other states, it provides outpatient treatment and does not house its participants in a high security setting. However, according to Texas officials, the Texas program has an annual cost of about $27,000 per offender, or about $74 per day.

Number of Commitments

Roughly 5,300 sex offenders were in civil commitment programs throughout the United States in 2010. Minnesota ranked third among the states—after

[21] States calculate per diem costs in different ways. Minnesota's per diem rate is a "fully loaded" rate that includes building depreciation, bond interest costs, and indirect costs, as well as operating expenditures. Other states typically include operating expenditures but do not always include some or all of these other types of expenses. However, even if we include only operating expenditures in Minnesota's per diem rate, Minnesota's rank remains at the fifth highest of 12 states.

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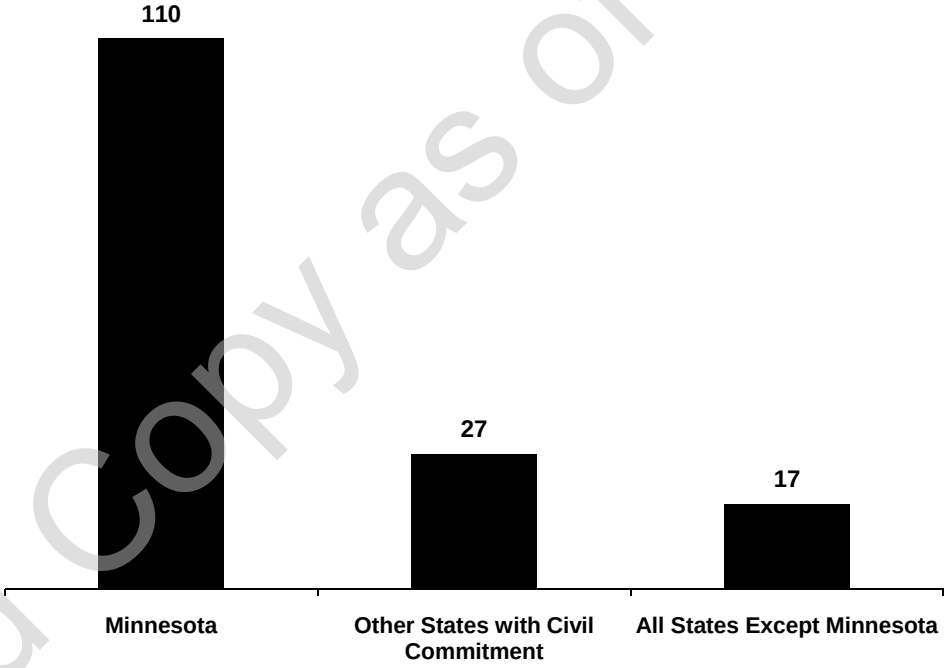
California and Florida—in the total number of civilly committed sex offenders. Furthermore:

- **Minnesota had the highest number of civilly committed sex offenders per capita in the nation in 2010.**

As Figure 1.4 indicates, Minnesota had 110 civilly committed sex offenders for each one million residents. Among other states with civil commitment programs, the average is 27 offenders per million residents. Among all 49 states except Minnesota, the average is 17 per million residents.

Minnesota has about four times the number of civilly committed sex offenders per capita as the average for the other 19 states with civil commitment programs.

Figure 1.4: Number of Civilly Committed Sex Offenders per Million Residents, 2010



SOURCES: Office of the Legislative Auditor, analysis of graphs from Rebecca Jackson, Jennifer Schneider, and Tara Trattia, "SOCCPN Annual Survey of Sex Offender Civil Commitment Programs," presentation to the Sex Offender Civil Commitment Programs Network annual meeting, October 18, 2010. Information on Nebraska was for 2009 and was obtained from the Minnesota Sex Offender Program.

Another perspective is that Minnesota has 1.7 percent of the nation's population and 2.7 percent of the population in states with civil commitment programs for sex offenders. However, in 2010, Minnesota had almost 11 percent of the nation's civilly committed sex offenders.

Number of Conditional Releases

It is also noteworthy that:

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While some other states have released offenders from civil commitment, no sex offender has ever been discharged from MSOP.

- **Minnesota has released no sex offenders from civil commitment and conditionally released only one offender, while some other states have made modest numbers of releases.**

Only one civilly committed sex offender has been conditionally released in Minnesota since at least 1994. That individual was returned to MSOP due to technical violations of his release conditions. He subsequently died while at an MSOP facility.

A report that examined states' commitments and conditional releases as of February 2004 found that the percentage of committed sex offenders that had been conditionally released was between 8 and 17 percent depending on which states were included in the analysis.[22] Some states in that analysis were like Minnesota in that very few civilly committed sex offenders had been conditionally released. But other states had conditionally released modest numbers of offenders. Wisconsin's civil commitment population has stabilized in the last several years as the number of releases has offset new commitments.

Commitment Laws

It is not entirely clear why Minnesota has so many more civilly committed sex offenders than other states. Some may suggest that other states simply incarcerate sex offenders longer. However, it is not possible to corroborate that hypothesis. Minnesota does have the second lowest prison incarceration rate among the states, but it is unclear whether this ranking applies to sex offenders. It could be that other states incarcerate sex offenders for similar prison terms as Minnesota but have higher incarceration rates than Minnesota for other types of offenders. Data are not available to make such a comparison. Furthermore, a comparison of state laws for sex offenses would provide insufficient information because it would not account for any interstate differences in prosecution, conviction, and sentencing practices.

Other possible explanations include interstate differences in: (1) referral, petition, and court practices; (2) legal standards for commitments; (3) legal requirements for commitment proceedings; and (4) differences in release practices. Few studies have looked at these factors, and even fewer have attempted to link the factors to differences in commitment rates.

In this section, we discuss some of the differences in commitment laws that may explain Minnesota's higher commitment rate. We do not attempt to examine differences in referral, petition, or court practices because we do not have detailed information from other states on the number of referrals, petitions, and

[22] Dennis M. Doren, "The Model for Considering Release of Civilly Committed Sexual Offenders," *The Sexual Predator: Law and Public Policy, Clinical Practice*, ed. by Anita Schlank (Kingston, New Jersey, 2006), 6-7 to 6-8. The analysis excluded Missouri and South Carolina because their statutes did not allow for conditional release at that time. In addition, Pennsylvania was excluded because no one had been committed at the time of the analysis. The range of results depends on whether one includes Texas and Arizona. In Texas, all civilly committed sex offenders are on conditional release and live in halfway houses in the community. In Arizona, most of the so-called conditional releases were to a less restrictive, but locked facility on the grounds of the state hospital.

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commitments per year. However, differences in practices may be as important as, or even more important than, differences in state laws in explaining the variation in commitment rates.

We found that:

- **Minnesota laws facilitate the civil commitment of sex offenders in a number of ways, perhaps contributing to Minnesota's relatively high use of civil commitment for sex offenders.**

It is difficult to attribute Minnesota's high commitment rates to any single set of factors.

As noted earlier, Minnesota laws specifically allow for commitment for offenses that involve emotional harm, as well as those involving physical harm or violence. In contrast, the statutes of most states require a violent offense for civil commitment, although the statutes do not necessarily define what constitutes violence. Minnesota requires two offenses while most states require only one. However, unlike most states, Minnesota does not require that the offenses resulted in convictions.

In several respects, Minnesota law makes it easier to civilly commit sex offenders. Minnesota does not allow offenders to request a jury trial for a civil commitment proceeding, while at least 15 of the other 19 states allow jury trials. Minnesota also allows hearsay evidence and requires the commitment standard to be met with "clear and convincing evidence" rather than proven "beyond a reasonable doubt."[23] State laws in six states including Minnesota explicitly allow hearsay evidence, while laws in five states explicitly prohibit hearsay evidence. In other states with civil commitment programs for sex offenders, state commitment laws do not appear to explicitly address the issue. About half of the states with civil commitment programs have the "clear and convincing" standard regarding evidence supporting commitment, while the others use the "beyond a reasonable doubt" standard.

Another way in which Minnesota differs from most states is in its lack of a required periodic report to the courts regarding each sex offender's continuing need to be committed. Most states require an annual report to be sent to the courts on each committed person as to whether the person continues to meet the commitment standard. Some states require mandatory court hearings, while others may only have a hearing if necessary. In some states, the state is required to reprove the commitment case in court periodically. Minnesota and Massachusetts appear to be the only two states where an annual report to the courts is not required.

Finally, in practice, Minnesota appears to have a release standard that is more restrictive than those in most states. Release standards are a product of both state laws and state agency policies and practices. Minnesota and other states with few conditional releases like North Dakota were described in a 2006 analysis as having a "treatment completion" standard.[24] On the other hand, states with more

[23] The "beyond a reasonable doubt" standard is a higher standard of proof than "clear and convincing" evidence, which is the minimum of proof required by the United States Supreme Court in civil commitment cases.

[24] Doren, Model for Considering Release, 6-18.

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conditional releases have a standard that indicates that someone should be discharged when he no longer meets the statutory criteria for commitment. Treatment completion states require offenders to fully complete the treatment program, which does not simply mean completing a course or courses of study. It generally means that offenders must demonstrate that treatment has had a significant impact on their behavior and thoughts. In other words, offenders must reduce their recidivism risk to very low levels. In contrast, other states allow for conditional releases when an offender's risk is reduced below the level required for commitment, even if they do not fully complete treatment.

Overall, it is difficult to attribute Minnesota's high commitment rates to any particular factor or set of factors. However, it does appear that some of Minnesota's laws and practices may contribute to those high rates. Lower incarceration rates may also be a factor, but it is hard to make interstate comparisons of incarceration for sex offenders alone.

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2 Civil Commitment Process

As discussed in Chapter 1, Minnesota has committed more sex offenders per capita than any other state. Furthermore, Minnesota continues to commit offenders at a relatively high rate, while none have been released. Some policymakers are concerned about the increasing costs of civil commitment. While also concerned about public safety, they wonder whether all of those being committed need to be confined in a high cost, high security setting.

This chapter reviews the civil commitment process for sex offenders and, in particular, the decisions made to commit sex offenders. First, we discuss the legal standards for commitment in Minnesota. Second, we provide background information on the process used to civilly commit sex offenders in Minnesota. Third, we examine the process used by the Department of Corrections to refer sex offenders to county attorneys for possible commitment. Fourth, we examine whether commitment decisions are being made on a consistent basis across the state. Finally, we discuss options for legislative changes in the commitment process and make some specific recommendations. We also consider whether some of those offenders being civilly committed could be treated in a community setting at a lower cost while still providing significant public safeguards.

STANDARDS FOR CIVIL COMMITMENT

Minnesota law provides for the civil commitment of sexually dangerous persons and individuals with sexual psychopathic personalities.

Minnesota first enacted a law to provide for indefinite civil commitment of certain dangerous sex offenders in 1939. That law provided for the civil commitment of sex offenders with a "psychopathic personality." In response to court decisions, the 1994 Legislature modified the law to provide for the commitment of people with a "sexual psychopathic personality."[1] Current law defines a person with a sexual psychopathic personality as a person who:

- is irresponsible for personal conduct with respect to sexual matters due to emotional instability, impulsive behavior, lack of customary standards of good judgment, or failure to appreciate the consequences of personal acts;
- has engaged in a habitual course of misconduct in sexual affairs;
- exhibits an utter lack of power to control the person's sexual impulses, and;

[1] *Laws of Minnesota* First Special Session 1994, chapter 1.

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- as a result, is dangerous to others.[2]

In addition, the 1994 Legislature created an alternative path to civil commitment. The Legislature defined a "sexually dangerous person" as a person who:

- has engaged in a course of harmful sexual conduct;
- has manifested a sexual, personality, or other mental disorder or dysfunction, and;
- as a result, is likely to engage in acts of harmful sexual conduct.[3]

It is not necessary to establish that an offender used or threatened physical harm with his victims in order to civilly commit him.

The Legislature adopted the sexually dangerous person definition in response to various court decisions. In particular, the Legislature allowed for the commitment of persons who did not exhibit an "utter" lack of power to control their sexual impulses. The new sexually dangerous person category also removed the requirement that the offender's history of sexual misconduct be "habitual." Finally, the new category allowed for civil commitment even if the offender's actions resulted in emotional harm only—rather than physical harm—to a victim. This was accomplished by: (1) defining "harmful sexual conduct" as sexual conduct that creates a substantial likelihood of serious physical or emotional harm to another, and (2) linking the conduct associated with certain offenses as creating a substantial likelihood that a victim will suffer serious physical or emotional harm.[4] The offenses directly linked with serious physical or emotional harm include criminal sexual conduct in the first, second, third, or fourth degree.[5] Additional offenses are considered to be associated with physical or emotional harm if the conduct was motivated by the person's sexual impulses or was part of a pattern of behavior that had criminal sexual conduct as a goal. Those offenses include harassment and stalking, terroristic threats, burglary in the first degree, arson in the first degree, tampering with a witness, incest, false imprisonment, kidnapping, simple or aggravated robbery, and certain types of assault, manslaughter, and murder.[6]

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[2] *Minnesota Statutes* 2010, 253B.02, subd. 18b.

[3] *Minnesota Statutes* 2010, 253B.02, subd. 18c.

[4] *Minnesota Statutes* 2010, 253B.02, subd. 7a. The law creates a presumption that the conduct associated with certain offenses creates a substantial likelihood that a victim will suffer serious physical or emotional harm. That presumption can be rebutted in court if a defendant provides sufficient evidence to the contrary.

[5] According to a Minnesota House of Representatives Research Department document, the first-degree and third-degree offenses typically involve sexual penetration of the victim, while the second-degree and fourth-degree crimes involve sexual contact without penetration. In addition, the first-degree and second-degree crimes generally apply to offenses involving personal injury to the victim; the use or threatened use of force, violence, or a dangerous weapon; or extremely young victims. The third-degree and fourth-degree crimes involve less aggravated conduct and apply when the victim did not consent, was relatively young, or was incapable of voluntarily consenting to sexual conduct due to a particular vulnerability or a special relationship with the offender. See Jeff Diebel, *Overview of Criminal Sexual Conduct Crimes* (St. Paul, July 2010).

[6] *Minnesota Statutes* 2010, 253B.02, subd. 7a.

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A court decision further clarified what is required for a civil commitment of a sexually dangerous person. Specifically, the prosecution must prove with clear and convincing evidence that a person:

- has engaged in a course of harmful sexual conduct;
- suffers from a current disorder or dysfunction; and
- the disorder or dysfunction does not allow the person to adequately control his or her behavior, thus making the person highly likely to commit harmful sexual acts in the future.[7]

A "course of harmful sexual conduct" consists of at least two offenses, which do not need to involve convictions and may involve the same victim. A "disorder" or "dysfunction" is usually a diagnosis by a psychologist of a sexual disorder like pedophilia or paraphilia, or a diagnosis of a personality disorder.

A majority of sex offender commitments in Minnesota are made under the sexually dangerous person statute. Based on information received from the Department of Human Services, we calculated that about 51 percent of those who were committed as of June 2010 were committed under the sexually dangerous person statute, while 11 percent were committed under the sexual psychopathic personality statute.[8] About 38 percent were committed under both statutes.

COMMITMENT PROCESS

The civil commitment process is initiated by a county attorney, generally following a referral from the Department of Corrections (DOC).

In Minnesota, the civil commitment process for sex offenders is initiated by any of Minnesota's 87 elected county attorneys. A county attorney that wants to commit a sex offender must file a petition with the district court. A petition may be filed by the county attorney from the county in which the offender is living. If the offender is incarcerated, the petition may be filed in the county where the conviction for which the offender is incarcerated was entered.[9]

Since 1991, the Department of Corrections (DOC) has assisted county attorneys by evaluating sex offenders who are scheduled to be released from prison. Based on its review, DOC forwards the names of sex offenders that the agency believes meet the commitment standard to county attorneys for their consideration. Although the vast majority of civilly committed sex offenders have been referred by DOC to county attorneys, some have not been referred. County attorneys may choose to file a civil commitment petition on an offender who has not been referred by DOC. Also, a district court may identify an offender as a candidate for commitment at the time of criminal sentencing. In that case, the court's determination is forwarded to the county attorney, who would consider whether to file a petition for civil commitment.

[7] Linehan IV, 594 N.W.2d 867, 876 (Minn. 1999).

[8] The group committed under the sexual psychopathic personality statute also includes anyone committed under the previous psychopathic personality statute.

[9] *Minnesota Statutes* 2010, 253B.185, subd. 1(b).

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In seven Minnesota counties (Hennepin, Ramsey, Dakota, Anoka, Washington, Olmsted, and St. Louis), county attorneys and their staff handle civil commitment cases in their entirety. In 75 of Minnesota's 87 counties, the Attorney General's Office (AGO) regularly handles civil commitment cases involving sex offenders on behalf of county attorneys. Another five counties (Stearns, Wright, Winona, Crow Wing, and Chisago) typically use the services provided by the AGO, but sometimes process a civil commitment petition without AGO's assistance. Whenever AGO handles a civil commitment or assists a county attorney's office, the county attorney determines whether or not to pursue a civil commitment. AGO provides services but leaves the higher-level decisions to the county attorney.

Counties using the AGO's services in civil commitment cases typically pay some of the costs of litigation but not the costs associated with the time spent by attorneys and other staff from AGO. Counties pay for litigation expenses such as expert witness fees, travel expenses for witnesses and the AGO's staff, and costs related to the gathering of records. However, the state pays the salaries and benefits of the AGO's staff who work on civil commitment cases for the counties.

Civil commitment trials are subject to different rules than criminal trials.

Those petitioned for commitment have the right to legal counsel at any commitment-related hearing. The court will appoint an attorney if the sex offender does not secure counsel on his own. However, as we noted in Chapter 1, there are a number of ways in which the rules and processes used in a commitment trial in Minnesota are different than those in criminal trials. For example, the person being considered for commitment does not have the right to a jury trial in Minnesota. Instead, the commitment case is decided by a district court judge. In addition, hearsay evidence is allowed in a commitment trial, while it is not permitted in a criminal trial. The court may also hear testimony about offenses that did not result in convictions and may consider evidence about such offenses even if it is hearsay evidence. Furthermore, the prosecution must demonstrate with "clear and convincing evidence" that the person meets the legal standard for commitment rather than the "beyond a reasonable doubt" standard that is used in criminal trials. If the person is found by the court to meet this standard, the court must commit the person to a secure treatment facility like those provided by the Minnesota Sex Offender Program (MSOP) unless the committed person establishes by clear and convincing evidence that a less restrictive treatment program is available and consistent with the person's treatment needs and public safety.

County attorneys often use experts to help them decide whether to file a petition. In addition, the court will appoint its own forensic psychologist to assist the court. This "examiner" assesses the recidivism risk posed by the sex offender and determines whether the offender has any relevant mental disorder that limits his ability to control his sexual actions. The sex offender has the right to have a second examiner appointed by the court and paid by the county attorney's office.

Some judges hear a large number of commitment cases while others may only hear an occasional case. For example, the district court in Hennepin County generally assigns one judge to hear sex offender commitment trials for a period of several years. A judge with that assignment may develop an expertise in that

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area. In some parts of the state, however, a judge may hear only one sex offender commitment case in many years.

Minnesota law also requires the treatment facility to which the person is committed to file a written treatment report within 60 days after initial commitment. The court must hold a hearing to review the treatment report unless both parties agree to waive the hearing. Following the hearing, the court must make a determination as to whether the person should be committed indefinitely. These hearings have rarely changed the results of an initial commitment.

Civil commitment trials are heard in district courts across the state.

Although civil commitment cases are heard by district courts throughout the state, Minnesota law authorizes the Supreme Court to establish a panel of district judges with statewide authority to preside over all sex offender commitment proceedings.[10] This law was enacted as a result of a recommendation from a 2005 Governor's task force on sex offenders.[11] The Supreme Court has not established such a panel.

REFERRALS

A key part of the commitment process is the identification of sex offenders who are scheduled to be released from Minnesota's correctional facilities and might be appropriate for civil commitment. In this section, we review the history of the referral process.

As noted earlier, in 1991 the Department of Corrections (DOC) began reviewing sex offenders for possible civil commitment following their incarceration. During the nearly 13 years up until December 2003, there was an annual average of about 26 referrals from DOC to county attorneys. About 61 percent of the referred offenders were committed.[12]

In December 2003, DOC made 236 additional referrals after an extensive review of sex offenders either incarcerated in prison or living in the community after release from prison. The number of referrals that month was more than 70 percent of the referrals that were made in the nearly 13 previous years. These new referrals came in response to the rape and murder of a college student in northwestern Minnesota by an offender recently released from a Minnesota correctional facility. About 31 percent of those sex offenders referred in December 2003 have been committed.

Since 2003, DOC has changed its review process. The pre-2003 review process involved a more informal review by three staff. Beginning in 2004, the DOC review became more formalized in terms of the criteria and process used to

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[10] *Minnesota Statutes* 2010, 253B.185, subd. 4.

[11] Governor's Commission on Sex Offender Policy, *Final Report* (St. Paul, January 2005).

[12] In making this and subsequent calculations, we eliminated any duplicate referrals. Duplicate referrals occur when DOC refers an offender to more than one county or in more than one year. In addition, we did not include any offenders whose cases are still under review by county attorneys or not finally decided by the courts. Over the 1991-2003 period, very few cases have not yet been completed. However, there are significantly more uncompleted cases in more recent years.

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conduct the review. Under current policies, the screening of each offender is done by a three-person team usually consisting of a DOC psychologist, a correctional facility staff person, and a staff person from DOC probation services. Their review consists of three stages. At the first stage, a computer program developed by DOC eliminates offenders from consideration based on their criminal history and other factors. Over the last four years (2006-09), about 17 percent of the sex offenders were eliminated at this stage. At the second stage, the three-person screening committee reviews the files of offenders. About 64 percent of the screened sex offenders were eliminated from consideration at this stage over the past four years. The third stage of review consists of a more detailed review of offenders, including interviews and the development of a report on each offender. At this stage of review, independent legal counsel under contract to DOC reviews the psychologist's report on each offender to see if the offender meets the legal standard for referral to a county attorney.[13] In addition, the Commissioner of the Department of Corrections reviews the reports on those offenders who are assigned a risk level of three but are not recommended for referral by the screening committee or legal counsel.[14] If the screening committee or legal counsel recommends referral or if the commissioner determines referral is appropriate, the department forwards the offender's name to the appropriate county attorney for possible civil commitment. Over the last four years, about 5 percent of the screened offenders were eliminated from consideration at this third stage of review. About 13 percent of screened offenders were referred to county attorneys for possible commitment.

About 70 percent of the referrals made by DOC were jointly supported by the three-person DOC staff review team and legal counsel over the last four years. Another 22 percent of referrals were supported by either the review team or legal counsel, but not both. Finally, 8 percent of the referrals came from the commissioner without support from either the review team or legal counsel.

The number of DOC referrals to county attorneys for possible commitment dramatically increased in December 2003.

With the implementation of this new process, there was a substantial increase in the number of referrals. More specifically:

- **During the five-year period from 2004 through 2008, DOC made about 157 referrals per year, or about six times the referral rate from January 1991 through November 2003.**

About 42 percent of the offenders referred during this five-year period have been civilly committed.[15]

The increase in referrals that began in December 2003 reflects a significant change in DOC's philosophy regarding the purpose of the department's review.

[13] The use of legal counsel in the review process began in 2005.

[14] A risk level of three is the highest level of risk assigned by DOC to sex offenders for community notification purposes. The assignment of risk levels is a separate process from the screening process for civil commitment.

[15] During 2009, DOC referred 114 offenders to county attorneys. It is too early to calculate a meaningful final commitment rate for offenders referred in 2009 and 2010.

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Prior to December 2003, DOC focused more on narrowing the list of sex offenders for possible civil commitment to those who were clearly dangerous. However, DOC was severely criticized by some, including the Governor, for not referring the sex offender who committed the rape and murder that occurred in the fall of 2003 in northwestern Minnesota. In December 2003, DOC changed its referral practices and began referring all sex offenders who qualified for commitment based on the legal standard, as well as some others who DOC believed might qualify. By referring more offenders, DOC reduced the chance of not identifying someone for possible commitment who might later commit a heinous sex crime.

DOC is required to refer any sex offender for whom a petition for commitment "may be appropriate."

This revised policy essentially passed the commitment decision in more cases to county attorneys. This policy makes sense if one believes that the legal system, and not DOC, should make decisions about which cases merit the filing of a petition and which offenders should be committed. DOC's policy is also consistent with state law, which requires the commissioner of DOC to refer those for whom a petition "may be appropriate."[16] Furthermore, the revised policy reduces the chance of failing to refer a sex offender who will later commit a heinous sex crime.

However, as we discussed in Chapter 1, the standard for commitment is relatively low, and many offenders qualify for commitment. As Figure 2.1 indicates:

- **A large increase in commitments has followed the substantial increase in DOC referrals since 2003.**

As of February 1, 2011, nearly 440 individuals, or about 68 percent of civilly committed sex offenders, were committed after 2003. The increase in commitments has not been as large as the increase in referrals. As noted above, the rate of commitment has declined as referrals increased. But the number of commitments has increased because the reduction in the commitment rate has been small relative to the large increase in the referral rate.

DOC's change in referral policy has two possible disadvantages. First, the increase in commitments has had a very significant impact on the costs of operating the Minnesota Sex Offender Program. Second, the revised referral policy increases the chance of referring an offender who will not reoffend or whose tendencies to reoffend could probably be managed through supervision and treatment in the community at a lower public cost than civil commitment to a high security MSOP facility.

[16] *Minnesota Statutes* 2010, 244.05, subd. 7.

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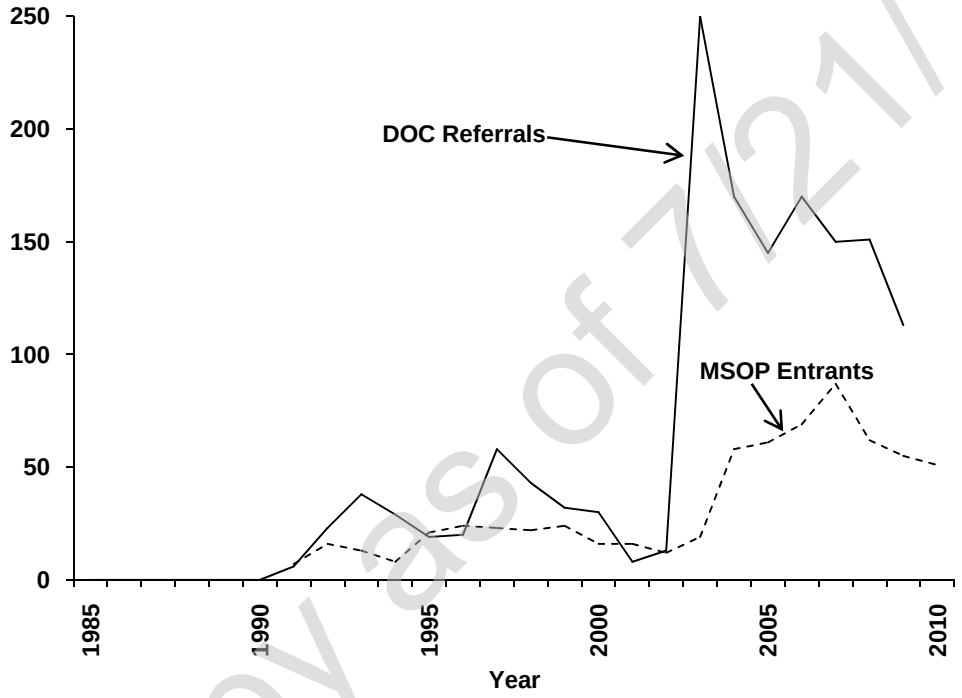
The number of civil commitments increased significantly beginning in 2004.

Figure 2.1: Referrals by the Department of Corrections and Numbers of Sex Offenders Entering the Minnesota Sex Offender Program, 1985-2010



NOTES: DOC started making referrals to county attorneys in 1991. The number of MSOP entrants was estimated using the date of admission for civilly committed offenders at MSOP or DOC facilities as of the end of 2010. In addition, we included the date of admission for previous MSOP residents who are now deceased.

SOURCES: Minnesota Sex Offender Program and the Department of Corrections.

VARIATION IN COMMITMENT PRACTICES

Under Minnesota law, the decisions regarding commitment are made in a decentralized manner. Even in counties where the Attorney General's Office handles commitment cases, county attorneys decide whether to file a petition to commit sex offenders. In addition, district court judges across the state hear commitment cases.

As a result, it is important to consider whether commitment decisions are being made in a consistent manner across the state. Without consistency, some offenders who would be committed in certain parts of the state would be released to the community in other parts of the state. Such inconsistency could result in: (1) the release of some offenders who are dangerous and should be committed, and/or (2) the indeterminate commitment of other offenders who are not a

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significant risk to the community, or who at least could be treated and supervised in the community at a lower cost with a relatively small risk to the community.

In examining the variation in commitment practices across the state, we conducted three types of analyses. First, we examined the variation in the number of sex offender civil commitments per capita in Minnesota's ten judicial districts. Second, we considered the variation by judicial district in the percentage of referred cases that resulted in commitments. We also reviewed the percentage of referrals that did not result in a petition filed by a county attorney and the percentage of cases in which a petition was filed but was either withdrawn by the prosecution or dismissed by a district court judge. Finally, we conducted a statistical analysis that isolates the impact of geographic location by controlling for known differences in the sex offenders that were referred, petitioned, or committed throughout the state. We discuss each one of these analyses below.

Commitments per Capita

As of July 2010, there were 12.2 civilly committed sex offenders in Minnesota per 100,000 residents.[17] We found that:

- **The number of commitments per capita varies significantly across the state.**

There is wide variation by county. The commitment rates by county vary from zero in a number of counties to nearly 61 per 100,000 residents.

There is significant variation across judicial districts in the number of civil commitments per capita.

In addition, there is significant variation across judicial districts. Figure 2.2 shows the location of Minnesota's ten judicial districts, and Figure 2.3 provides information on the commitments per capita for each judicial district. The latter figure shows that the number of commitments per 100,000 residents is the highest in the Third Judicial District (19.5) in southeastern Minnesota and the Ninth Judicial District (19.1) in northwestern Minnesota. The number is also well above the state average in the Fifth Judicial District (16.7) in southwestern Minnesota and the Seventh (15.3) and Eighth (17.0) judicial districts, which are both in west central Minnesota. The Second Judicial District in Ramsey County (12.0) and the Fourth Judicial District in Hennepin County (12.1) both have slightly below average numbers of commitments per capita. The numbers of commitments per capita are further below average in the judicial districts immediately north and south of Hennepin and Ramsey counties. The First Judicial District has 6.7 commitments per 100,000 residents, and the Tenth Judicial District has 7.9 commitments per 100,000 residents. The Sixth Judicial District (8.5) in northeastern Minnesota also has a lower than average number of commitments per capita.

[17] This figure includes the 627 sex offenders held at MSOP and DOC facilities as of July 2010, as well as 18 deceased MSOP residents. We included the deceased residents because we wanted the commitments per capita to reflect all the commitments that have been made. We included nine MSOP residents who are there on a judicial hold but have not been finally committed. Most judicial holds result in a commitment.

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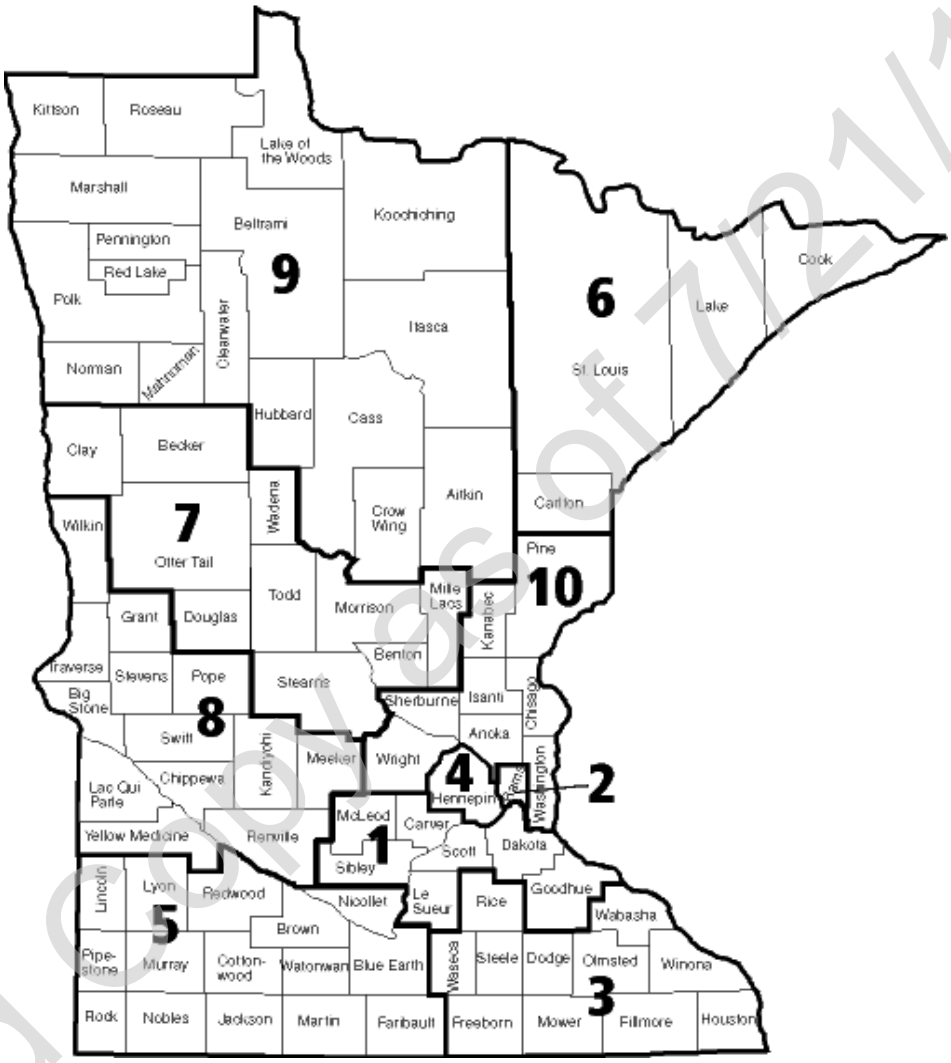
Figure 2.2: Minnesota Judicial Districts, 2010



SOURCE: Minnesota State Court Administrator's Office.

It should be noted that there is also considerable variation within each judicial district with more than one county. For example, in the Third Judicial District, the number of commitments per 100,000 residents ranges from zero in one county to over 34 in another county. However, a majority of counties in the district have above average numbers per capita, including all six of the most populous counties in the district. As a result, despite this variation, the Third Judicial District has the highest number of commitments per capita of any district in the state.

Another way to look at this variation is to group the counties by population size. For example, we compared the seven most populous counties in the state with all the other counties. These "high population" counties—which include Hennepin,

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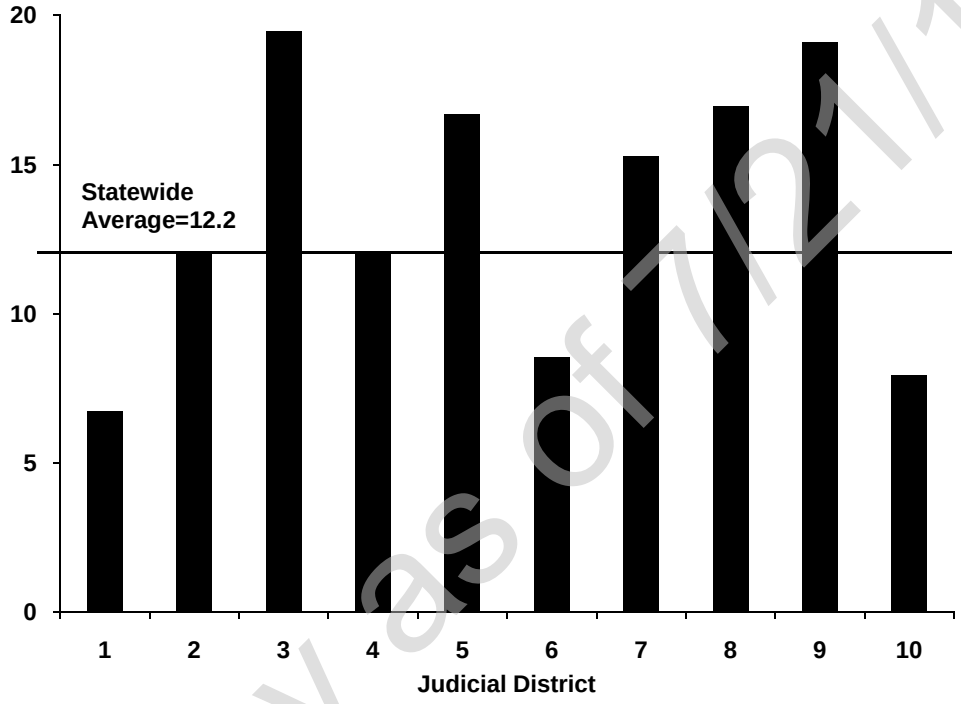
The number of civil commitments per capita is the highest in the southeastern and western parts of the state.

Figure 2.3: Sex Offender Civil Commitments per 100,000 Residents by Judicial District, as of July 2010



NOTES: Commitments include 627 offenders held at MSOP and DOC facilities, including nine offenders held at MSOP on a judicial hold and not yet committed. We also included 18 offenders who died while residing at MSOP. Population estimates were for 2008.

SOURCE: Office of the Legislative Auditor, analysis of data from the Minnesota Sex Offender Program and the State Demographer's Office.

Ramsey, Dakota, Anoka, Washington, St. Louis, and Stearns counties—all have below average numbers of commitments per capita. As a group, the "high population" counties have 10.0 commitments per 100,000 residents, compared with an average of 15.1 for the other 80 counties.

We also compared the counties based on the level of involvement of the Attorney General's Office (AGO) in civil commitment cases. For those counties in which AGO handles all civil commitment cases, the number of commitments per 100,000 residents is 15.1, which is above the state average. In contrast, the number is 10.6 in those seven counties not served by AGO and 10.7 in the five counties that use AGO for most, but not all, cases. It is unclear that AGO's involvement is responsible for this variation, since county attorneys make the decision about whether to submit a petition for commitment. However, counties do not have to pay the salaries and benefits paid to AGO attorneys and other staff working cases for them. It is possible, though unproven, that county attorneys may be more inclined to file a petition when some of the prosecution costs are paid by the state.

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Commitments as a Percentage of Referrals

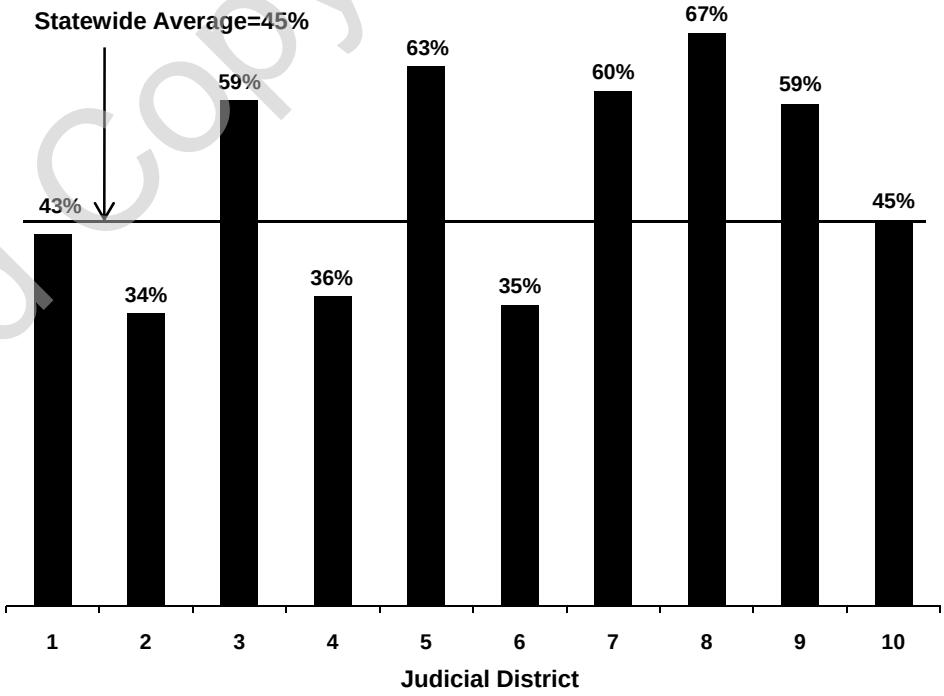
We also examined the variation in commitment rates across the state. Since the vast majority of commitments result from referrals, we defined a "commitment rate" as the number of commitments as a percentage of referrals from the Department of Corrections. We found that:

- **There is significant variation across the state in the percentage of referrals that result in commitments, and that variation is somewhat similar to the variation in commitments per capita.**

From 1991 through 2008, 45 percent of DOC referrals resulted in the civil commitment of a sex offender. Figure 2.4 shows that, among the ten judicial districts, the commitment rates have varied from 34 percent to 67 percent.[18] The lowest rates, which range from 34 to 36 percent, are in Ramsey and Hennepin counties and northeastern Minnesota. The highest commitment rates, which range from 59 percent to 67 percent, are in southeastern, southwestern, west central, and northwestern Minnesota. The commitment rates in the judicial districts to the immediate north and south of Hennepin and Ramsey counties are either average or slightly below average.

Across judicial districts, the percentage of referrals that result in civil commitments ranges from 34 percent to 67 percent.

Figure 2.4: Percentage of Referrals Resulting in Civil Commitments by Judicial District, 1991-2008



SOURCE: Office of the Legislative Auditor, analysis of data from the Department of Corrections.

[18] As with commitments per capita, these averages mask significant variation by county.

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The lowest commitment rates are in Hennepin and Ramsey counties and northeastern Minnesota.

This pattern of variation is somewhat similar to the variation in commitments per capita. All five judicial districts with above average commitments per capita have above average commitment rates. In addition, all five districts with below average commitments per capita have below average commitment rates. However, Hennepin and Ramsey counties have slightly below average commitments per capita, but they have commitment rates (commitments as a percentage of referrals) that are well below average. The judicial districts immediately north and south of Hennepin and Ramsey counties have commitments per capita that are well below average, but they have commitment rates that are slightly below the state average. These differences in the pattern of variation can be explained by differences in referrals per capita. The first and tenth judicial districts have slightly below average commitment rates and well below average numbers of referrals per capita. As a result, their number of commitments per capita are also well below average. Hennepin and Ramsey counties have the highest referral rates per capita. When combined with lower than average commitment rates, these two counties have slightly below average numbers of commitments per capita.

As was the case for commitments per capita, "high population" counties also have below average commitment rates. As Table 2.1 indicates, the seven most populous counties have an average commitment rate of 36 percent compared with an average of 56 percent for the other 80 counties. The table also shows that the main reason for the lower commitment rate in the "high population" counties is that:

- **On average, county attorneys in the seven most populous counties file a petition for commitment in a smaller percentage of cases than county attorneys in other counties.**

Table 2.1: Outcome of Sex Offender Referrals by Population of County, 1991-2008

Outcome	Seven Highest Population Counties[a]	All Other Counties
Committed	36%	59%
County Attorney did not file a petition	56	26
Petition dismissed or withdrawn	8	15
Total	100%	100%

[a] These are the seven counties in Minnesota with the highest overall number of residents in 2008. They include Hennepin, Ramsey, Dakota, Anoka, Washington, St. Louis, and Stearns counties.

SOURCE: Office of the Legislative Auditor, analysis of data from the Department of Corrections.

In other words, county attorneys in the "high population" counties generally appear to be more selective in bringing commitment cases to court than their counterparts elsewhere across the state. On average, the county attorneys in the seven most populous counties filed a petition for commitment for 44 percent of the referrals. In the other counties, county attorneys filed a petition for commitment for 74 percent of the referrals.

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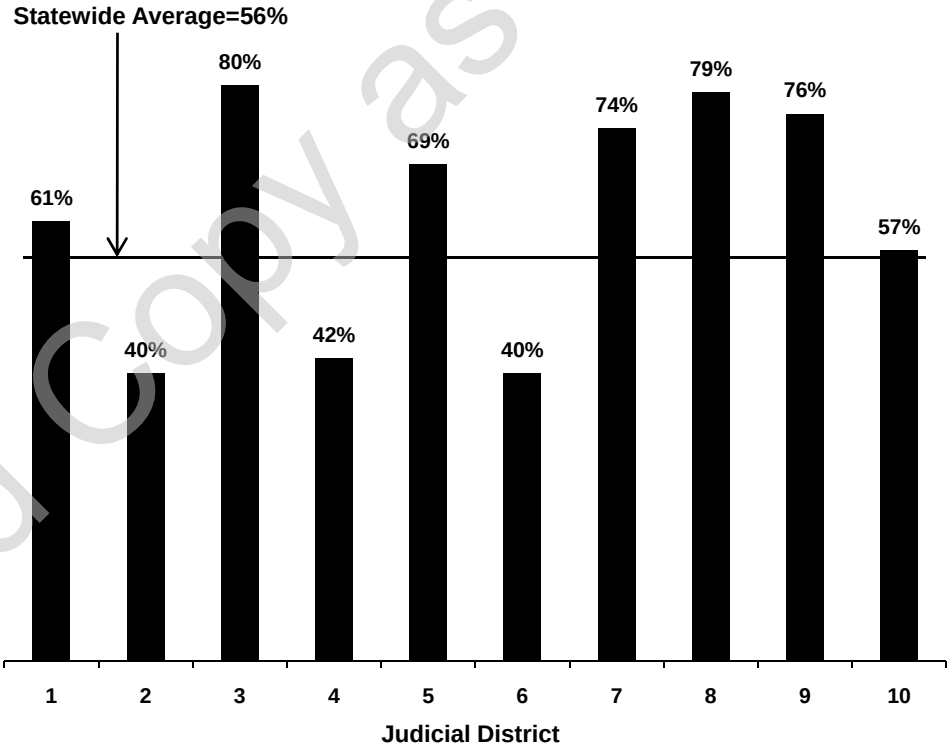
Among those cases brought to court, the two groups of counties do not differ much in the percentage of cases that resulted in a civil commitment. In the seven most populous counties, 82 percent of the referred cases in which a petition was filed resulted in a commitment. About 80 percent of the petitions resulted in a commitment in the other 80 counties.

Figure 2.5 illustrates the differences in petition rates by judicial district. Petition rates—or the percentages of referrals which result in petitions filed for commitment—vary from 40 to 80 percent. Petition rates are the lowest in Hennepin and Ramsey counties and northeastern Minnesota. The rates in two judicial districts immediately to the north and south of Hennepin and Ramsey counties are a little above the statewide average of 56 percent. Petition rates in the other five judicial districts range from 69 to 80 percent.

Much of the variation in commitment rates is due to differences in the decisions made by county attorneys to bring referred cases to court.

Figure 2.5: Percentage of Referrals Resulting in Petitions for Civil Commitment by Judicial District, 1991-2008



SOURCE: Office of the Legislative Auditor, analysis of data from the Department of Corrections.

As Figure 2.6 indicates, court commitments as a percentage of petitions filed are high and do not vary as much as petition rates. Commitments as a percentage of petitions range from 71 to 91 percent and do not follow the same geographic pattern as petition rates. The judicial districts with higher than average commitments as a percentage of petitions include districts with lower than average petition rates and districts with above average petition rates.

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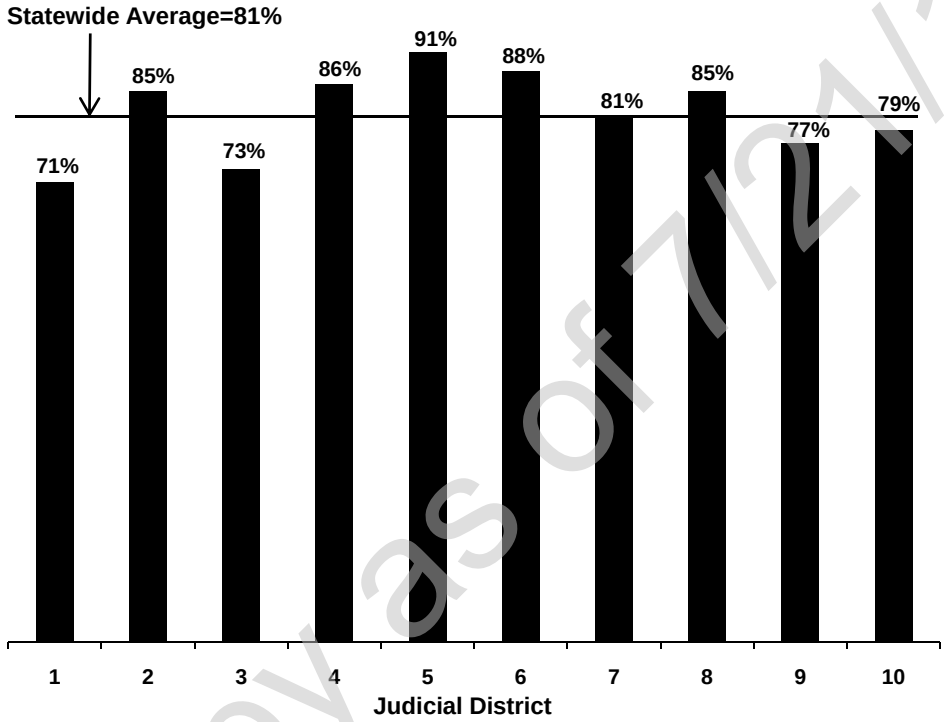
There is also some variation across district courts in the percentage of petitions that result in civil commitments.

Figure 2.6: Percentage of Petitions Resulting in Civil Commitment by Judicial District, 1991-2008



SOURCE: Office of the Legislative Auditor, analysis of data from the Department of Corrections.

Statistical Analysis

The previous analyses strongly suggest that there are significant variations in commitment practices across the state. However, the differences in commitment rates could be the result of differences in the characteristics of the sex offenders being referred across the state. For example, the lower commitment rates in "high population" counties would be explainable if sex offenders being referred in the "high population" counties were less dangerous on average than those being referred in other counties. While there is no reason to believe that this is true, we used a statistical analysis to determine if the county or judicial district in which the referral was made had an impact on the outcome of a commitment case.

More specifically, we used logistic regression analysis to examine the relationship between the commitment outcome and various factors related to the recidivism risk of the offender. These factors included the types and numbers of an offender's crimes, types of victims, scores on actuarial assessment instruments, treatment history, prison disciplinary history, probation history, diagnoses of mental disorders, reported sex abuse as a child, education, race, age,

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and geographic location.[19] The purpose of using regression analysis was to isolate the effect of location while controlling for the types of offenders being considered for commitment throughout the state. In addition to examining the decisions of courts on commitment, we also examined the decisions by county attorneys to file petitions and the decisions by DOC to refer offenders.

In order to examine all three types of decisions—referral, petition, and commitment—we used data from DOC. These data are in DOC computer and paper files and are used by DOC during the referral process. Information on referred offenders is then passed on to county attorneys.[20] Our focus was on a stratified random sample of offenders who had been reviewed by DOC during a three-year period (2006-08). Overall, we gathered data on 474 offenders—including 292 offenders who were referred to county attorneys and 112 offenders who reached the final stage of DOC review but were not referred.[21]

The geographic variation in petition and commitment practices cannot be explained by differences in the characteristics of offenders and their crimes.

Effect of Location

In this section, we examine whether the geographic variation we found in commitment rates is substantiated by the logistic regression analyses. Our analyses isolate the impact of geography while controlling for the impact of other factors. The results of our analyses confirm that:

- **There is significant geographic variation in petition and commitment rates across the state that is unexplained by the characteristics of offenders and their crimes.**

Furthermore:

- **The geographic variation in petition and commitment rates is similar to the variation in commitment rates and commitments per capita.**

For example, we found that the probability that a petition for commitment is filed on an offender is significantly higher if the county attorney reviewing the case is

[19] Actuarial assessment instruments are used to estimate the chances that an offender will commit another crime in the future. The instruments included in our analysis were the Minnesota Sex Offender Screening Tool – Revised (MnSOST-R) and the Static-99, since DOC generally utilizes these tests in its review of offenders for possible civil commitment. Actuarial scores are considered to be the best predictors of future recidivism, but are not perfect in their predictions. Offenders with identical scores are, on average, expected to commit a future offense with equal likelihood, but their chances of recidivism will vary to a certain extent. Existing literature suggests that clinical judgment alone, or combined with actuarial scores, does not improve the predictability of recidivism over that provided by actuarial scores alone.

[20] Additional information is developed by prosecutors and the courts during the petition and commitment process. However, this information is not generally computerized or stored in a central location. As a result, it would have been difficult for us to review enough cases for a statistical analysis. Furthermore, the information could not have been used to evaluate the referral process.

[21] We also gathered information on 70 offenders who reached the second level of DOC review but did not progress beyond that stage. These offenders were not included in our analysis when we compared referred offenders to those not referred.

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from a county other than the seven most populous counties in Minnesota.[22] Similarly, the probability that a petition is filed is significantly higher than in the Fourth Judicial District (Hennepin County) if the petition is being considered by a county attorney in any judicial district other than the Sixth Judicial District (northeastern Minnesota). The probability is the highest in the same parts of the state—southeastern, southwestern, west central, and northwestern Minnesota—that we found had higher than average commitment rates and higher than average numbers of commitments per capita.

Furthermore, the regression analysis of commitment decisions showed that the probability that a sex offender who was referred by DOC was civilly committed is significantly higher if the case is prosecuted by a county attorney from a county other than the seven most populous counties in Minnesota. In addition, the probability that an offender who was referred by DOC was committed was significantly higher than in Hennepin County in all judicial districts except the Second Judicial District (Ramsey County) and the Sixth Judicial District (northeastern Minnesota).[23] Again, these results are similar to the differences in commitment rates discussed earlier.

The inconsistency in commitment practices suggests that Minnesota is committing sex offenders in some parts of the state who would be released from prison in other parts of the state.

This inconsistency in commitment decisions suggests that either Minnesota is civilly committing too many sex offenders in some parts of the state, or is committing too few sex offenders in other parts of the state, or both. Alternatively, it suggests that Minnesota has a low bar to meet for civil commitment. As a result, prosecutors have considerable discretion in determining who to commit and who to release. In some parts of the state, prosecutors choose to petition a greater percentage of those who meet the requirements for commitment. The vast majority of those petitions result in civil commitments. In any event, the inconsistency implies that:

- **Minnesota is committing some sex offenders who probably have a lower risk of recidivism than some of those being released.**

Or, alternatively, Minnesota is releasing some sex offenders who probably have a higher risk of reoffending than some of those being committed.

Finally, we compared sex offenders referred by DOC with those who reached the final level of DOC review but were not referred. We found that:

- **Geographic location generally does not affect referral decisions.**

Our regression analysis showed that there was no significant difference in the probability of an offender being referred between the seven most populous

[22] More specifically, we compared offenders who were referred by DOC but not petitioned with offenders who were referred by DOC and were the subject of a petition for commitment filed by a county attorney.

[23] In one of the two different regressions we ran, the probability of commitment in the Tenth Judicial District was not significantly different from that in Hennepin County. One of these regressions used various diagnoses such as pedophilia or personality disorders as independent variables. The other regression did not use these diagnosis variables, but instead used alternative variables such as intelligence impairments, brain injuries, major mental illnesses, mood disorders, and post-traumatic syndrome as independent variables.

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counties and the other 80 counties. In addition, there was no significant difference in the probability of an offender being referred between most judicial districts and the Fourth Judicial District (Hennepin County). However, in both regression analyses we conducted, offenders from the Second Judicial District (Ramsey County) had a significantly lower chance of being referred than offenders from Hennepin County. In one of the two regressions, offenders from the Third Judicial District (southeastern Minnesota) and the Sixth Judicial District (northeastern Minnesota) had a significantly higher chance of being referred than offenders from Hennepin County. It is unclear why these exceptions to the general findings for referrals occurred.

Effect of Other Factors

To some extent, decisions made during the commitment process are based on assessments of the recidivism risks of offenders.

Some of the other results from the statistical analysis indicate that decisions made by those involved in the commitment process are, at least in part, evidence-based. For example, we found that:

- **Higher scores on actuarial assessment instruments that are indicative of higher recidivism risks are associated with increased probabilities of an offender being referred, petitioned, and committed.**

Higher scores on the MnSOST-R and the Static-99 are indicative of higher recidivism risks. In each of four regressions, higher scores on one of the actuarial instruments or both were associated with higher probabilities of an offender being referred.[24] Similar results were obtained for petition and commitment decisions. These results are encouraging in that they suggest that the most important information available to decision makers is being used. However, the results for geographic location and some other variables suggest that other factors that should not be considered are playing a role in these decisions. A number of these other factors are discussed below.

We also found that:

- **Caucasians were more likely to be petitioned and committed than minorities, but their chances of being referred were not different.**

There was no significant difference in the odds of being referred for Caucasians relative to minorities. However, all four regressions showed that Caucasians had a significantly higher probability of being petitioned for commitment. Three of four regressions indicated that Caucasians had a significantly higher probability of being committed than minorities.

In addition:

[24] The four regressions included two regressions using diagnosis variables. In one of these, the geographic variable indicated whether a county was one of the seven most populous counties or not. In the other, the geographic variables indicated the judicial district in which the county was located. These two different sets of geographic variables were also used in regressions involving the alternative variables such as brain injuries rather than the diagnosis variables.

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- **Having an offense in which a weapon was used or the victim was physically injured raised the odds of being referred but not the odds of being petitioned or committed.**

The effect of prior treatment and treatment failures on decisions made during the commitment process is complicated.

We also examined the effect that prior treatment or a prior treatment failure had on referral, petition, and commitment decisions. The effects of treatment were mixed.[25] For example, we found that:

- **Having been enrolled in any sex offender treatment program at any point in time raised the odds of being referred, lowered the odds of being committed, but generally did not affect the odds of being petitioned.**

Treatment participation may increase the odds of referral for two reasons. First, more dangerous offenders may be more likely to have been enrolled in treatment at least once. They may have a longer criminal history and may be more likely to have been ordered to treatment than offenders with fewer offenses. In addition, sex offender treatment at Minnesota's correctional facilities is generally targeted toward more serious offenders. Second, treatment professionals generally encourage participants to reveal all of their offenses including those for which they have not been convicted. Those admissions can be used to establish a case for commitment. On the other hand, participation in treatment may be indicative of progress in reducing the risks of recidivism. It is unclear why treatment participation appears to affect referral and commitment decisions differently and does not appear to affect petition decisions.

In addition, we analyzed the impact of treatment failures on decisions made during the commitment process. A treatment failure occurred when the offender left treatment before completion or was removed from treatment for lack of progress, a sexual offense, or a violation of other rules. We found that:

- **Having had any failure in treatment increased the odds of commitment, reduced the odds of referral, and did not generally affect the odds of being petitioned.**

Again, the reasons for these different results are not entirely clear. It makes some sense that having experienced a treatment failure might increase the odds of commitment, but it is less clear why a failure affects referral and petition decisions differently. It is possible, however, that having a treatment failure means that an offender did not discuss his past offenses during treatment sessions, including offenses that were not reported, were not charged, or were charged but did not result in convictions. The lack of disclosure could mean that officials making the referral or petition decisions were aware of fewer offenses for offenders with one or more treatment failures compared with offenders who

[25] We examined the effect on referral, petition, and commitment decisions of: (1) having participating in any sex offender treatment program and (2) having failed to complete any sex offender treatment program. A potential problem with the treatment variables we used is that they may not adequately summarize an offender's entire treatment history. For example, an offender could have had a treatment failure ten years ago, but successfully completed a treatment program more recently. Alternatively, an offender could have successfully completed a short treatment program ten years ago, but has failed in numerous treatment programs in subsequent years.

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participated in treatment successfully and disclosed past offenses. As a result, it could be less likely for offenders with treatment failures to be referred or petitioned.

COMMITMENT ALTERNATIVES

Minnesota lacks a less costly commitment alternative to the high security facilities at Moose Lake and St. Peter.

One problem with Minnesota's commitment process is that it results in an all-or-nothing outcome. The decision that prosecutors and judges face is that either a sex offender is civilly committed in an expensive, high security facility, or the offender is released to the community, sometimes with no supervision if he has served his complete prison sentence. In particular:

- **Minnesota lacks options for committing offenders and placing them in less costly settings with adequate supervision and treatment.**

Minnesota law allows judges to consider less restrictive settings to the secure facilities operated by MSOP. A judge may commit the offender to a less restrictive facility if the offender establishes by clear and convincing evidence that a less restrictive treatment program is available and is consistent with treatment needs and public safety.[26] While some judges have been willing to consider alternatives to committing certain offenders, there are no available alternatives that provide adequate supervision. There is only one other residential treatment program in Minnesota for sex offenders, but that program will not accept any sex offenders who are being considered for civil commitment. As a result, this provision in law is currently of virtually no practical use in commitment decisions involving sex offenders. Prosecutors and judges thus face a choice between release with no public safeguards and placement in the costly, high security MSOP facilities. There are no lower-cost alternatives that would provide needed treatment and adequate public protection.

One such alternative would be to place certain committed offenders in group homes in the community under MSOP's supervision, provided the courts determined that they could be safely managed in that setting. The offenders would be under constant supervision and GPS monitoring and would receive treatment. If the offenders violate the terms of their commitment, they could be moved to the secure facilities in Moose Lake or St. Peter. Alternatively, they could be sent back to prison, as Texas does, if they fail to attend treatment or violate the conditions of their commitment. As we noted in Chapter 1, the outpatient civil commitment program in Texas provides treatment and housing in four halfway houses specifically for civilly committed offenders. In addition, the Texas program provides close supervision and monitoring of committed individuals, all for an annual cost of about $27,000 per offender.

Another option would be to stay the commitment of an offender and allow the offender to live in the community. A person under a stay of commitment could also be subject to a treatment directive and be under intensive supervision.

[26] *Minnesota Statutes* 2010, 253B.18, subd. 1. This subdivision specifically applies to the civil commitment of mentally ill and dangerous individuals. However, it also applies to the civil commitment of sex offenders due to the language in *Minnesota Statutes* 2010, 253B.185, subd. 1.

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Offenses or violations of the conditions of the stay would result in a revocation of the stay and commitment to a secure treatment facility.

The current stay of commitment option needs to be modified in order to be suitable for use with sex offenders.

Current law provides a stay of commitment option for sex offenders, and that option has been used in a few instances.[27] However, the stay provision was designed primarily for mentally ill or chemically dependent populations and not sex offenders. As a result, there are no provisions for MSOP, DOC, or county community corrections agencies to supervise or monitor sex offenders who receive a stay. Instead, supervision would be provided by a social service agency. In addition, there are currently limited options for treatment in the community for those on a stay of commitment. The lack of adequate funding for supervision and treatment of those on a stay of commitment is also a concern. Finally, the conditions that the offender must meet to avoid revocation of a stay are not spelled out in statute but are completely left up to the court to determine. Statutory provisions more appropriate to sex offenders would be needed to make the stay of commitment a viable option for the courts and to ensure adequate protection for the public.

It could also be argued that the financial incentives for counties, combined with the lack of alternatives to MSOP, help to increase the number of commitments of sex offenders in Minnesota. Counties pay $32.80 per day, or about $12,000 per year, for each offender at MSOP facilities for which they are financially responsible. Through commitment, county officials can remove an offender from their jurisdiction at a reasonable cost, or at least a cost that may compare favorably with the risks the county would face if the offender was released to the community. However, the overall cost to the public is about $120,000 per year for each offender, with the state paying 90 percent of the cost. If the counties paid a higher share of the costs, county attorneys might commit fewer individuals. If less costly alternatives were available and counties were required to pay the same percentage of costs as they do for commitments to MSOP facilities, county attorneys might also be amenable to those alternatives when they are appropriate. Implementing alternatives to commitment could not only save money for both the state and counties but could be done in a way that provides adequate protection for the public if implemented properly.

A less restrictive setting may be appropriate not only for some of those being considered for commitment in the future, but also for some of the existing population at MSOP facilities. There is some reason to think that:

- **Minnesota may be committing some sex offenders who could be treated and supervised in other less costly settings.**

Professionals we interviewed—including MSOP clinicians and outside psychologists who assess sex offenders for the courts—generally agreed that some sex offenders at MSOP facilities could be treated in less secure community settings, although they disagreed about what percentage of MSOP residents could be successfully managed in other settings. In addition, as we will explore further in Chapter 3, MSOP clinical management agreed that some low functioning

[27] *Minnesota Statutes* 2010, 253B.095.

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Some MSOP residents, particularly certain low functioning individuals, could be supervised in a less costly setting.

individuals in the MSOP alternative program in St. Peter could be managed in group homes specifically designed for low functioning sex offenders. Elderly individuals with numerous medical problems and physical disabilities are also being committed and sent to MSOP facilities and placed in an assisted living unit when appropriate. Most recently, an 88-year-old was committed and sent to an MSOP facility. Some of these individuals may be suitable for an alternative commitment setting.

In addition, some MSOP residents—beyond those mentioned above—may be suitable for placement in a less costly community setting provided that there is appropriate supervision and monitoring of their activities and that there are appropriate consequences for violations of the rules. These individuals may not meet Minnesota's high standard for release, but their recidivism risk may be significantly less than when they were admitted and less than the level required for commitment. Professionals would have to assess their current risk levels to see if they might be suitable for an alternative commitment setting.

It should also be recognized that Minnesota has the highest number of civilly committed sex offenders per capita in the nation and has not released any offenders from MSOP facilities. In contrast, some other states are releasing offenders from their facilities, and others such as Texas and New York have some or all of their civilly committed sex offenders living in community settings. It appears that these practices in Texas and New York are successful in managing costs and in preventing sexual recidivism, provided that offenders have stable housing arrangements and that authorities maintain intense supervision and monitoring.

As we noted earlier in this chapter, Minnesota is also releasing some sex offenders from prison who are probably more dangerous than some of the offenders being committed. Instead of committing these less dangerous offenders to the secure facilities at Moose Lake and St. Peter, Minnesota could establish less expensive commitment alternatives for them and the more dangerous offenders who are being released. By doing so, Minnesota could control its costs and provide protection for the public from a larger number of offenders.

Finally, utilizing alternatives to civil commitment could help stretch the available resources so that intensive supervision of sex offenders released from prison could be extended beyond the usual one-year period where necessary. Since many sex crimes are committed by offenders without a prior conviction for a sex crime, investments in cost-effective prevention efforts could also be considered.

RECOMMENDATIONS

Without changes to the civil commitment process, the number of sex offenders housed at MSOP facilities is expected to nearly double in ten years. MSOP's budget will also grow significantly although it need not grow as fast as the population due to cost efficiencies associated with larger populations. While MSOP provides a safer alternative than community placements, community placements can be effective from a public safety standpoint provided that

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appropriate safeguards are taken and intensive supervision of offenders is provided on a continuing basis. In addition, the Legislature could provide additional safeguards for the public by increasing the length or intensity of supervision of other sex offenders released from prison or increasing prevention efforts. As a result, there are opportunities for the Legislature to reduce the costs of civil commitment over time. The following recommendations are options that the Legislature could use in pursuing that goal.

First, we recommend that the Legislature consider implementing a continuum of options. In addition to the current option of commitment at a secure MSOP facility, these options might include: (1) commitment to a less restrictive facility, and (2) stays of commitment. In either of these cases, treatment should be a required activity. In addition, intensive supervision and monitoring should be required. Finally, there should be consequences if an offender violates the conditions of his commitment or stay of commitment, including transfer to a secure MSOP facility.

As an alternative to a significant expansion of existing facilities, MSOP should present a plan to the 2012 Legislature for alternative facilities and an enhanced stay of commitment option.

The costs of MSOP have grown significantly in the past and will likely grow more in the future due to the expected increase in the civilly committed population. The expected population growth will require a significant increase in the bed capacity of MSOP's facilities and additional staff and other resources. Implementing a continuum of options will require some additional funding from the Legislature. However, by using less costly facilities and stays for some individuals, the Legislature can probably lower the overall costs of the program below projected costs under current law.

In addition, MSOP would need appropriate statutory language to ensure adequate supervision and monitoring and to spell out the process to be followed if offenders in less restrictive facilities or on stays of commitment fail to comply with the conditions of their commitment or stay of commitment. However, we think the first step in this process is to get a better idea of how these options would work and how they might affect the costs of MSOP in the future.

RECOMMENDATION

The Legislature should require MSOP to develop a plan for alternative facilities for use by certain sex offenders currently at MSOP, as well as for certain newly committed individuals. The plan should provide details about funding and needed statutory changes to ensure adequate supervision, monitoring, and treatment of these sex offenders. The plan should also address the funding and statutory changes needed to address a stay of commitment option. The cost impact of these options should be compared with the costs of expected growth at MSOP without any change in policy. The plan should be presented to the 2012 Legislature.

In preparing this plan, MSOP will also need to reassess its existing residents to see which residents would be suitable for placement in an alternative setting.

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RECOMMENDATION

MSOP should reassess its existing residents to determine which residents would be suitable for placement in an alternative setting. The plan presented to the 2012 Legislature should provide information on this reassessment, including the rationale for determining why certain types of residents would be suitable for an alternative commitment setting and a detailed description of the alternative settings being proposed for various groups.

Changes in sentencing policies for sex offenders could be considered but will not affect the number of civilly committed sex offenders for many years.

Some might argue that outside experts should be used to do this assessment, since they might be more objective in their assessments. However, as an initial step in developing this plan, we suggest that MSOP staff conduct this reassessment. In the future, if the Legislature required transfers from the high security MSOP facilities to community options to be approved by the Supreme Court Appeal Panel, outside examiners could be used by the panel.

Another option for the Legislature to consider is indeterminate sentencing for certain sex offenders. In order to reduce costs, the system of indeterminate sentencing would need to be designed so that it does not increase overall prison sentences for sex offenders by threefold or more. In addition, it should be recognized that the implementation of indeterminate sentencing will not begin to address the current costs at MSOP and their expected growth for many years. The expected growth in MSOP's population over the next decade is largely expected to come from current prison inmates who were sentenced under existing laws.

RECOMMENDATION

The Legislature should consider providing for indeterminate sentencing for some sex offenders. As a condition of their release, offenders could be required to successfully complete treatment in prison.

Another sentencing option would be to increase the length of sentences for certain sex offenders, such as those convicted of first-degree criminal sexual conduct. Such an option would take a considerable time before it would affect the number of civil commitments. In addition, it might significantly increase correctional costs. Finally, it might not be effective in preventing the civil commitment of some dangerous sex offenders, since only about 42 percent of those who have been committed had a first-degree criminal sexual conduct conviction.

In addition to these recommendations, there are other options the Legislature could consider to increase the consistency of commitment decisions and reduce expensive commitments, while continuing to maintain public safeguards. We offer no explicit recommendations on these options, but we think they deserve the Legislature's consideration.

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For example:

- **The Legislature could consider providing funding for a centralized commitment court and a centralized prosecution and assessment unit.**

In light of the inconsistencies in commitment practices, changes in the commitment process and structure are worth considering.

The Legislature has authorized the Supreme Court to create a centralized court for processing commitment cases, but the court has not created one. Because the court system has experienced budget problems in recent years, fully funding a centralized commitment court would provide an incentive for the Supreme Court to establish such a court. However, we are not sure that centralizing the court decisions will increase consistency in commitment decisions or reduce the number of commitments without additional changes. If prosecutors in some parts of the state are more inclined to bring commitment cases than in other parts of the state, a centralized court might not by itself bring about more consistency. The court would have to commit any offender petitioned by a county attorney who meets the legal standard. Creating a centralized prosecution and assessment unit might also help, but it will also be helpful to implement alternatives to MSOP commitment—like stays of commitment and commitments to a less restrictive alternative—so that the court and prosecutors have alternatives to consider.

In addition:

- **It may be useful for the Legislature to consider raising the legal standard for commitment to require at least one or two convictions or more than two total offenses.**

- **The Legislature could also consider assuring offenders the same level of procedural protections—such as jury trials, the inadmissibility of hearsay evidence, and the "beyond a reasonable doubt" standard for evidence—in commitment trials as are required in criminal trials.**

However, if the Legislature changes the commitment standard, it might lose the ability to supervise and monitor certain sex offenders who could be committed to less restrictive settings or whose commitment could be stayed. Changing the commitment standard could also affect existing commitments if the Legislature also changes the release standard to match the commitment standard as is suggested in Chapter 3.

The large increase in DOC referrals that began in December 2003 appears to have had a significant impact on the number of commitments. Some increase in referrals was needed because DOC was not previously referring some potentially dangerous sex offenders. However, the six-fold increase in referrals may not have been necessary and served to increase commitment rates. As a result:

- **The Legislature could consider changing state law to provide the Department of Corrections with more explicit direction on referrals.**

It is unclear, however, exactly what specific direction would be appropriate to put into state law to get the DOC to be more selective in who it refers to county

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attorneys. Current law directs DOC to refer those sex offenders who are appropriate for a petition for commitment. DOC refers those who meet and might meet the commitment standard and leaves it up to prosecutors to decide which offenders should be the subject of petitions for commitment. The real issue is whether the commitment standard is too low.

The Legislature should also consider the incentives to counties under the current system of financing MSOP and prosecution costs.

Finally:

- **The Legislature could consider changes to the system of financing the costs of MSOP and civil commitment prosecution.**

Changes would be of particular interest as long as county attorneys are still responsible for filing petitions for commitment and there are no alternatives to commitment at the secure facilities in Moose Lake and St. Peter. The Legislature could increase the county's share of the cost of commitment, or alternatively increase the county's share substantially but only for additional commitments beyond the number of commitments for which the county is currently financially responsible. If the Legislature provides for alternatives to commitment at Moose Lake and St. Peter, the county's share could be maintained at 10 percent for any placement including those at Moose Lake and St. Peter. Counties would then pay a lower rate for alternatives than they do for Moose Lake and St. Peter. Alternatively, the Legislature could increase the county's share for new commitments at Moose Lake and St. Peter and reduce the county's share for less costly alternatives. That would create an even greater incentive for counties to look seriously at alternatives. Finally, the Legislature could consider making counties using the services of the Attorney General's Office pay for a portion of the salaries and benefits of the AGO staff working on civil commitment cases.

Because there are many possible changes to consider, we suggest that alternatives to the existing commitment process and commitment standard be studied by a stakeholder group during the interim.

RECOMMENDATION

The Legislature should direct the Department of Human Services to convene a task force to consider the need for changes in the sex offender commitment standard and process, including the advisability of establishing a centralized prosecution structure and a single commitment court for sex offenders. The Legislature could also direct the department to have the task force examine the referral process. The task force should be required to report its findings and recommendations to the 2012 Legislature.

The members of the task force should include prosecutors, judges, defense attorneys, and others with a specialized knowledge and interest in these issues. Legislators should also be represented on the task force.

Regardless of the recommendations of the task force, we think that the statutes governing the civil commitment of sex offenders should be separated from those

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governing the civil commitment of others, including mentally ill and dangerous, mentally ill, chemically dependent, and developmentally disabled populations.

RECOMMENDATION

The Legislature should direct the Department of Human Services to work with stakeholders and the Office of the Revisor of Statutes to develop a proposal for separating the civil commitment statutes for sex offenders from those governing the civil commitment of other populations.

In most states with civil commitment programs for sex offenders, the statutes governing the civil commitment of sex offenders were developed independently of their general civil commitment statutes. As a result, the civil commitment statutes for sex offenders in most other states are probably clearer and better tailored to the sex offender population than in Minnesota.

Further study is needed of the recidivism rates of sex offenders who have been referred or petitioned for civil commitment but not civilly committed.

It is also important to consider the implications of the variation across the state in petition and commitment rates. As mentioned earlier, the variation is significant and suggests that some offenders being released from prison in some parts of Minnesota have a higher risk of recidivism than some offenders being civilly committed in other parts of the state. While it is not possible to measure the recidivism rates of those who have been civilly committed, the Department of Corrections could study the recidivism rates of those who have been referred or petitioned for civil commitment but not committed.

RECOMMENDATION

The Legislature should direct the Department of Corrections to study the recidivism rates of sex offenders who have been referred or petitioned for civil commitment and not civilly committed and report back to the 2012 Legislature. The department should also analyze whether there are geographical differences in the recidivism rates for these populations. These recidivism rates could also be compared to the rates experienced by other sex offenders who have been released from prison but not referred for civil commitment.

By examining geographical differences in recidivism rates, the department may be able to shed some light on the impact of the current variation in petition and commitment practices.

Finally, we think it is important for the Legislature to consider the importance of funding treatment in Minnesota correctional facilities and community settings as a tool in reducing the need for more costly civil commitment options. To the extent that programs are effective, they may diminish the need for civil commitment. In particular, the treatment program operated by MSOP at the Moose Lake Correctional Facility is designed to treat inmates who are the most likely candidates for civil commitment. The program attempts to reduce the costs of civil commitment by reducing the number of offenders who need to be

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civilly committed and reducing the length of their stay at MSOP facilities if they are committed. Although MSOP has operated the program for about ten years, it has been under different management in the last three years. It is difficult to determine whether this program has reduced the need for civil commitment or will reduce the need in the future as a result of recent management changes. Of those who have participated in the program in the past ten years, about 66 percent have been civilly committed.[28] It is uncertain, however, what percentage of participants would have been committed in the absence of their participation in the MSOP treatment program or whether the length of the stay of those committed to MSOP facilities has been reduced. It is also unclear, at this point, what effect changes made three years ago will have on the program's effectiveness.

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[28] In calculating the percentage committed, we excluded 49 offenders who are still in the program and whose final status is unknown because their commitment cases are pending or they have not yet been reviewed for possible commitment.

3 MSOP Treatment

Successfully treating clients by reducing their risk of reoffending and safely releasing them or moving them to less costly settings is essential to controlling the population growth and costs of the Minnesota Sex Offender Program (MSOP). Offering adequate treatment to these clients is also important for maintaining the constitutionality of the program. However, no client has ever been permanently discharged from MSOP, and there are currently few clients nearing completion of the program.

In this chapter, we focus on those aspects of the treatment program that may contribute to clients' failure to progress and be released from treatment. We first discuss the legal requirement to provide treatment. We then review what is known about the effectiveness of sex offender treatment and the best treatment models for sex offender treatment. We examine the type and amount of treatment delivered to clients at MSOP facilities, the adequacy of clinical staffing at MSOP facilities, and the therapeutic environment at MSOP facilities. We also discuss how client progress is evaluated, as well as how the program meets the special needs of some clients. Finally, we discuss the process and standard for releasing clients from MSOP.

To address these topics, we reviewed relevant literature on sex offender treatment and risk assessment. We examined in detail the records of a stratified random sample of 41 clients who had been committed for at least four years. In addition, we reviewed material contained in two Special Review Board hearing files and two additional complete client files which were not part of our sample. We interviewed clinicians at both St. Peter and Moose Lake, conducted four focus groups with clients at both locations, and interviewed experts and advocates outside of MSOP. We also visited the Sand Ridge facility for civilly committed sex offenders in Wisconsin, and we interviewed officials and reviewed material about programs in other states.

LEGAL REQUIREMENT FOR TREATMENT

Civilly committed sex offenders retain certain rights. In particular, they have a right to receive treatment or other training that will give them an opportunity to regain some or all of their rights to liberty.[1] Providing treatment is evidence that

[1] In Youngberg v. Romeo, 457 U.S. 307, 322 (1982), the United States Supreme Court held that civilly committed persons retain a right to minimally adequate treatment or training that will allow them to exercise some or all of their liberty rights. While this case did not explicitly apply this holding to civilly committed sex offenders, other courts have found the right to treatment to exist for civilly committed sex offenders as well. For example, see Turay v. Seling et al., 108 F.Supp.2d 1148 (W.D. Wash. 2000).

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the purpose of civil commitment is not to punish the committed individual, but rather is to address the conditions that led to a person's commitment.[2]

Civilly committed sex offenders have a right to treatment.

The Minnesota Supreme Court has held that Minnesota's civil commitment laws do not violate offenders' fundamental rights to liberty and due process so long as treatment and periodic review is provided.[3] While civilly committed sex offenders in Minnesota, therefore, have a right to adequate treatment, the United States Supreme Court has held that courts should defer to the judgment of treatment professionals in judging what treatment is constitutionally adequate in the context of civil commitment programs.[4] The standard for reviewing whether treatment is adequate is whether treatment professionals exercised their professional judgment in running the treatment program.[5]

While this may be a low bar for judging treatment programs, a federal court found that the program administrators in the state of Washington failed to exercise their professional judgment in running their civil commitment program, resulting in a 13-year injunction while the program corrected the treatment program. In that case, the court found that the treatment program had so departed from minimal professional standards that the treatment professionals must not have based their treatment decisions on their professional judgment. Some of the conditions which led to the injunction included: inadequate staffing, inadequate training of staff regarding the clinical mission of the facility, the lack of individualized treatment, the absence of arrangements for clients to transition to being released, inadequate provisions to allow clients' families to participate in treatment, and a punitive treatment environment.[6]

As a result:

- **It is important that any civil commitment program for sex offenders offer adequate treatment to those in the program.**

A court could consider failure to release offenders from civil commitment as evidence that inadequate treatment is being provided or that the purpose of the program is punitive rather than rehabilitative. It should be noted, however, that participation in treatment is voluntary. Residents at a civil commitment facility may decline treatment, but a facility must at least offer each resident the opportunity to participate in treatment.

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[2] Kansas v. Hendricks, 521 U.S. 346, 367-369 (1997). Providing treatment also assures that the conditions and duration of confinement bear a reasonable relation to the purpose for which persons are confined, another requirement of due process. See Seling v. Young, 531 U.S. 250, 265 (2001) citing Foucha v. Louisiana, 504 U.S. 71, 79 (1992), Youngberg v. Romeo, 457 U.S. 307, 324 (1982), and Jackson v. Indiana, 406 U.S. 715, 738 (1972).

[3] In re Blodgett, 510 N.W.2d 911, 916 (Minn. 1994) established this principle for sex offenders committed under the sexually psychopathic personality statute. The Minnesota Court of Appeals explicitly applied this holding to those committed under the sexually dangerous person statute. See In re Harrison, No. A07-1181, 2007 WL 4305377, at 7.

[4] Youngberg v. Romeo, 457 U.S. 307, 323 (1982).

[5] *Ibid.*

[6] Turay v. Seling et al., 108 F.Supp.2d 1148 (W.D. Wash. 2000).

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EFFECTIVENESS OF SEX OFFENDER TREATMENT

Most research suggests that certain types of sex offender treatment can reduce recidivism.

The purpose of treating sex offenders is to reduce their risk of reoffending so that they may be safely released. We reviewed the literature on effectiveness of sex offender treatment in reducing sexual recidivism. We found that:

- **Most research suggests some positive impacts from sex offender treatment.**

Several meta-analyses of sex offender treatment studies have found lower rates of recidivism among treated offenders compared to untreated offenders.[7] These studies are often cited in the treatment community as evidence that sex offender treatment reduces recidivism. For example, a 2002 meta-analysis found that cognitive behavioral treatments resulted in a reduction of sexual recidivism from 17.4 percent to 9.9 percent.[8]

Another meta-analysis from 2005 found a 6 percentage point, or 37 percent, reduction in sexual recidivism for offenders that had participated in treatment.[9] While these studies showed significant reductions in sexual recidivism, a sex offender's risk of reoffending will never be zero.

We also found that:

- **Existing research suggests that cognitive behavioral therapy that adheres to the principles of risk, need, and responsivity is most effective for reducing sex offender recidivism.**

Cognitive behavioral treatment targets attitudes, beliefs, and behaviors that are believed to increase the likelihood of sexual offenses.[10] The principles of risk, need, and responsivity require that the intensity of treatment conforms to the risk posed by the individual needing treatment (risk), that treatment targets behaviors and ways of thinking that are linked to reoffending (need), and that treatment be adapted to an individual's learning style and needs (responsivity).

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[7] A meta-analysis is a study which reviews and summarizes the results from existing studies in a particular area of interest.

[8] Karl Hanson et al., "First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders," *Sexual Abuse: A Journal of Research and Treatment* 14, no. 2 (April 2002): 169-194.

[9] Friedrich Losel and Martin Schmucker, "The Effectiveness of Treatment for Sexual Offenders: A Comprehensive Meta-Analysis," *Journal of Experimental Criminology* 1 (2005): 117-146.

[10] Studies supporting the use of cognitive behavioral therapy for sex offenders include Hanson et al., "First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders;" Karl Hanson et al., "The Principles of Effective Correctional Treatment Also Apply to Sexual Offenders," *Criminal Justice and Behavior* 36, no. 9 (September 2009): 865-890; and Steve Aos, Marna Miller, and Elizabeth Drake, *Evidence-Based Adult Corrections Programs: What Works and What Does Not* (Olympia, WA: Washington State Institute for Public Policy, 2006).

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However, there is some disagreement about the effectiveness of sex offender treatment in general. It has been argued that:

- **Many studies of the effectiveness of sex offender treatment do not use the best research methods for isolating and measuring the impact of treatment.**

However, some questions remain about the effectiveness of sex offender treatment.

For example, the vast majority of studies do not use random assignment or other matching techniques to assure that the group of sex offenders who received treatment is similar in its characteristics and risks to the group of sex offenders who did not receive treatment. Without such assurance, it is not possible to tell for certain whether a difference in recidivism rates is due to the treatment or inherent differences in the groups. For example, the group of offenders who did not receive treatment may be higher risk or less willing to change than the offenders who did receive treatment. These differences, rather than treatment's effects, may explain the differences in recidivism. Meta-analyses have also included studies of treatment programs that were very different or outdated, studies with differing definitions of recidivism, studies with small numbers of participants, and studies with short follow-up times.

Two recent, well-designed studies came to opposite conclusions about the effectiveness of sex offender treatment. One widely cited study by Marques and others used strong research methods, a long follow-up period, and a relatively large sample.[11] The authors randomly assigned offenders in a California prison who volunteered for treatment to either receive two years of inpatient cognitive behavioral treatment and relapse prevention treatment or to remain in prison and receive no treatment. The study also randomly selected an additional nonvolunteer control group that did not receive treatment. After release, offenders were tracked for eight years to collect data on any sexual or violent recidivism. The study found no significant differences between the three groups in their rates of sexual and violent offending over the follow-up period.

The Minnesota Department of Corrections (DOC) recently published a study of recidivism of sex offenders who received treatment in DOC facilities.[12] The study looked at the recidivism of 2,040 offenders who were followed for an average of 9.3 years. Offenders who received treatment were statistically matched with offenders who did not receive treatment in order to assure that differences in recidivism between the groups were due to treatment. Offenders in the treatment group received DOC's one to three-year intensive cognitive behavioral treatment program for sex offenders. The study showed that the sexual recidivism rate was 27 percent lower for offenders who entered treatment than those who did not participate in treatment.

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[11] Janice Marques et al., "Effects of a Relapse Prevention Program on Sexual Recidivism: Final Results from California's Sex Offender Treatment and Evaluation Project (SOTEP)," *Sexual Abuse: A Journal of Research and Treatment*, 17 no. 1 (January 2005): 79-107.

[12] Grant Duwe and Robin Goldman, "The Impact of Prison-Based Treatment on Sex Offender Recidivism: Evidence from Minnesota," *Sexual Abuse: A Journal of Research and Treatment*, 21 no. 3 (September 2009): 279-307.

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The studies discussed above used different methods of matching untreated and treated groups of offenders and came up with different results. While the DOC study and the earlier meta-analyses results are promising, until more studies like the Marques study are completed, it is impossible to offer more definitive conclusions about sex offender treatment's effect on recidivism.

In addition:

- **Another unresolved issue in sex offender treatment research is whether treatment is effective for the type of high-risk offenders who are civilly committed.**

We are not aware of any studies that have attempted to address this question. In fact, it would be difficult to assess the effects of treatment for a population that, for the most part, has not been released. There is some evidence, however, that the highest risk offenders—psychopaths—may actually have an increased risk of reoffending following treatment.[13]

MSOP'S TREATMENT PROGRAM

Although there is no definitive research demonstrating the effectiveness of sex offender treatment in reducing recidivism, sex offender civil commitment programs must offer adequate treatment to civilly committed persons in order to survive constitutional scrutiny. In this section, we describe the treatment program at MSOP facilities. In particular, we focus on whether the type and amount of treatment is appropriate for civilly committed individuals at MSOP facilities. We also discuss the adequacy of clinical staffing, the impact of changes in clinical leadership on the treatment program, and the therapeutic environment at MSOP facilities.

Background

Treatment at MSOP facilities consists of three phases of indeterminate length.

MSOP delivers sex offender treatment in therapy groups and psychoeducational classes. As the program is designed to be residential and intensive, clients are also expected to learn and demonstrate behavior change in daily life. Therapeutic goals are laid out in a "treatment matrix," which is divided into three phases. There are no timelines associated with completion of any of the phases or the treatment program as a whole. In Phase One, clients are expected to learn how to comply with facility rules and learn basic treatment concepts. In Phase Two, clients are expected to disclose their sexual offenses and understand their patterns of sexual abuse. The first two phases of treatment are delivered at the Moose Lake facility. Phase Three of treatment is provided at the St. Peter facility and focuses on community reintegration. The St. Peter facility also houses the alternative program, a modified program for cognitively disabled clients.

[13] For a discussion on these studies, see Howard Barbaree, Calvin Langton, and Edward Peacock, "Sexual Offender Treatment for Psychopaths: Is It Harmful?" in *Sexual Offender Treatment: Controversial Issues*, eds. William Marshall, et al. (West Sussex: John Wiley & Sons Ltd., 2006), 159. Due to concerns regarding the treatment of psychopaths, MSOP has a separate unit for clients with high psychopathy with unique programming.

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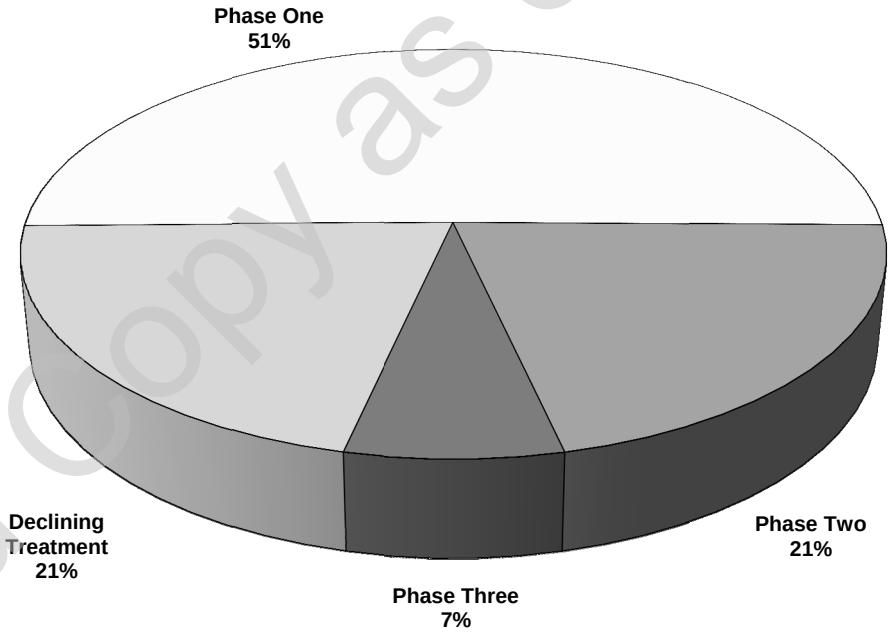
Phase Three is further divided into two phases—MSOP Supervised Integration (MSI) and Community Preparation Services (CPS). In MSI, clients continue to live within a secure area, but they gradually gain privileges to take accompanied outings on and off campus and eventually unaccompanied outings on campus. In CPS, clients live on campus in a house and another facility that is not within the secure perimeter. Clients make unaccompanied on-campus trips and accompanied off-campus trips. The movement of both MSI and CPS clients is electronically monitored.[14]

As shown in Figure 3.1, as of June 30, 2010, about 50 percent of clients were in Phase One, 21 percent were in Phase Two, and 7 percent were in Phase Three. About 21 percent had declined treatment. Of the 40 clients in Phase Three, 5 were in CPS.

Close to 80 percent of MSOP clients are participating in treatment.

Figure 3.1: Minnesota Sex Offender Program Client Population by Treatment Phase, 2010



NOTES: Represents 542 clients as of June 30, 2010, and excludes clients in the MSOP admissions unit, clients being held prior to commitment, and committed clients being held at the Department of Corrections or in local jails. This chart includes clients in all phases of the alternative program.

SOURCE: Department of Human Services, *Minnesota Sex Offender Program (MSOP) Quarterly Report: Moose Lake, St. Paul, and St. Peter*, 2nd Quarter, 2010.

[14] MSOP also runs a treatment program at DOC's Moose Lake Correctional Facility for inmates who have not been committed, but face a high likelihood of being committed. The DOC program also uses the matrix and phase system, but does not have the MSI and CPS components. We did not evaluate the joint MSOP/DOC program. When we refer to MSOP, we are referring to the program that operates at the Department of Human Services sites in Moose Lake and St. Peter.

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Clients of the program are indefinitely committed. Decisions to move the client to CPS or to grant provisional or final discharge are made by a three-member judicial panel called the Supreme Court Appeals Panel (SCAP) following a recommendation by a Special Review Board (SRB). The SRB is an independent three-member panel made up of a mental health professional, a psychiatrist, and an attorney. SRB decisions may be appealed to the SCAP. In 2003, the governor issued an Executive Order barring the release of any MSOP clients unless required by law or ordered by a court.

Prior to 2008, the SRB would make recommendations on transfers, provisional discharges, and discharges directly to the Commissioner of Human Services. The commissioner's decision was appealable to SCAP. In 2008, the Legislature enacted a law which removed the commissioner from the SRB process and made SCAP the decision maker.[15] To date, no clients have been discharged from the program.

Type of Treatment at MSOP

MSOP delivers a type of treatment that is recommended by existing research.

One of the important issues about sex offender treatment at MSOP facilities concerns the type of treatment provided. We examined whether the type of treatment delivered at MSOP facilities is what current research suggests is most effective for reducing recidivism among sex offenders. We found that:

- **MSOP's current model of treatment conforms to what current research suggests is most effective in reducing recidivism in sex offenders**.

MSOP's current approach to treatment is based on cognitive behavioral therapy and the treatment principles of risk, need, and responsivity. As noted earlier, current research suggests that cognitive behavioral therapy, which adheres to the principles of the risk, need, and responsivity, is most effective for reducing sex offender recidivism.

Cognitive behavioral treatment at MSOP facilities seeks to promote changes in offenders' thinking and behavior through group therapy and psychoeducational classes. This therapy aims to help offenders learn about their ways of thinking and behaviors that led to committing their offenses. In addition, the residential program seeks to provide a 24-hour therapeutic environment where clients are expected to demonstrate that they have changed through their behaviors on the living unit, in recreation, at work, and in education classes.

Treatment at MSOP facilities consists primarily of six hours of group therapy. Group therapy is commonly used in sex offender treatment programs. Individual therapy is provided only in special circumstances in Moose Lake. Individual therapy is available to clients in Phase Three of the program at St. Peter.

[15] *Minnesota Statutes* 2010, 253B.185, subd. 9.

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Staffing

In order for meaningful and intensive treatment to take place, MSOP must have leaders and supervisors to develop and implement a treatment program as well as clinicians to deliver treatment to clients. In this section, we discuss some of the challenges the program has faced in staffing clinical positions and establishing consistent clinical leadership. Clinical staffing has been more of a problem at Moose Lake than in St. Peter.

Clinical Leadership

MSOP has had four clinical directors in the last seven years.

Clinical leaders should develop a treatment program based on research, literature, and theory. They should develop the model of treatment and treatment expectations, and direct clinicians on how to deliver treatment. Stable leadership and a consistent treatment program supports clients in progressing through a long-term treatment program. We found that:

- **Frequent leadership changes have contributed to a lack of continuity in MSOP's treatment program.**

The program has had three executive directors and four executive clinical directors in the last seven years. Due to these many leadership changes, the content of the treatment program at MSOP facilities has changed multiple times since 2003. With each change in leadership and the treatment program, clinicians and clients have needed to learn the new program. Also, clients have had to be reassessed according to new program requirements. At times, clinicians have lacked supervision to help them make good clinical decisions. Because of changes in MSOP's leadership and the treatment program, the program has not been able to deliver consistent treatment to its residents.

The current executive director of MSOP took the position in March 2008. At that time, there was no executive clinical director of the program and there had been no executive clinical director since May 2007. The current executive clinical director was hired in July 2008. We found that:

- **The current MSOP administration is working to stabilize the clinical program after years of inconsistent and unstable clinical leadership.**

Figure 3.2 shows the clinical leadership structure of the program. The executive clinical director quickly established two new positions – clinical directors for both the Moose Lake and St. Peter facilities. The executive clinical director, along with these facility clinical directors, established the new treatment program, including the phase system and treatment matrix currently in use. This program will be discussed in more detail later in this chapter.

The St. Peter facility clinical director has been in place since December 2008. The Moose Lake facility has had two clinical directors since this position was first filled in September 2008. Maintaining consistent clinical leadership is essential to filling current vacancies, retaining existing clinical staff, maintaining a long-term treatment program, establishing consistent treatment expectations,

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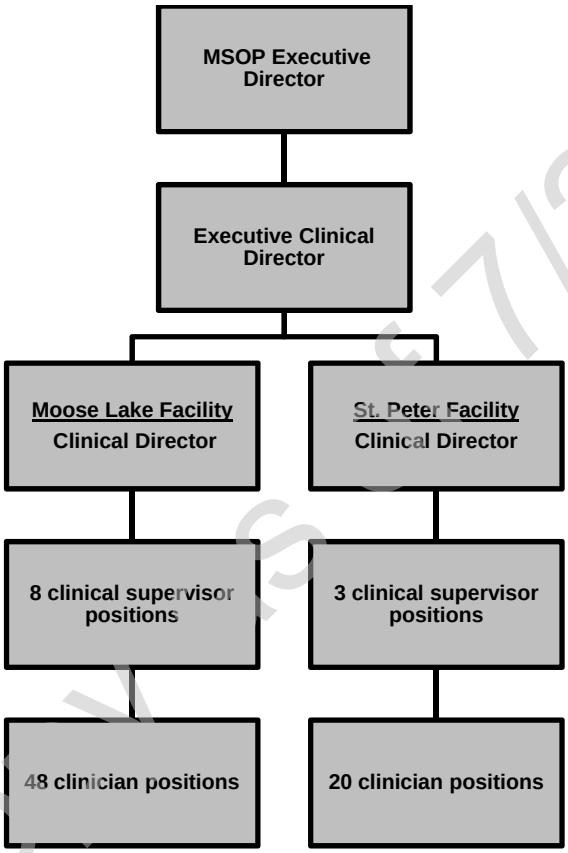
Figure 3.2: Clinical Organizational Structure of Minnesota Sex Offender Program, 2010



NOTES: Figure represents MSOP organizational structure related to clinical staffing only, and excludes rehabilitation department staff providing education, vocation, and recreation services. "Clinicians" include clinicians running groups and treatment psychologists. Figure shows the number of positions, including all vacant positions.

SOURCE: Minnesota Sex Offender Program.

While clinical supervisors are essential to ensure consistency of treatment, MSOP has had difficulties filling supervisory positions in Moose Lake.

and giving clients the hope of release that is essential to maintaining motivation to complete treatment.

Clinical Supervision

Clinical supervision is an essential part of creating a cohesive and effective treatment program. Clinical supervisors are responsible for assuring that clinicians are following best practices when conducting treatment groups, training new clinicians, making final decisions regarding whether a client progresses or is moved to another unit, and assuring that the treatment program is implemented in a consistent manner. We found that:

- **MSOP has had difficulty filling clinical supervisor positions at the Moose Lake facility.**

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At one point, the facility had only two clinical supervisors and six clinical supervisor vacancies. When we interviewed one of these two supervisors, her caseload had recently decreased to 224 clients because a third clinical supervisor had just been hired. As of January 2011, four of eight clinical supervisor positions were filled.

With a dearth of clinical supervisors, MSOP has been unable to assure that all clinicians are implementing a therapeutic style consistent with best practices or applying the treatment model in the way the clinical directors envision. Clinicians we interviewed at Moose Lake stated that they did not feel that everyone was "on the same page" in terms of administering the treatment model established by the current administration. The executive clinical director told us that MSOP has actively taken steps to recruit and retain qualified staff. In addition, she has taken steps to introduce videotaping of treatment groups in order to assure that all clinicians are delivering therapy in appropriate and effective ways.

Clinician Staffing

Clinical vacancies in Moose Lake have hampered the ability of clinicians to deliver treatment.

The program has had continuing problems maintaining clinical staffing levels and keeping pace with growth in the client population. As of November 2010, 17 of 68 nonsupervisory clinical positions were vacant. Sixteen of these vacancies were at the Moose Lake facility. Since then, MSOP has worked rapidly to hire clinicians. As of January 2011, five clinical vacancies remained at Moose Lake. Overall, we found that:

- **Clinician caseloads at Moose Lake have been too high due to clinician turnover and many clinical vacancies.**

Clinical understaffing has been a very serious problem, which has affected the ability of the program to deliver treatment to clients. The executive clinical director said the goal—with a fully staffed program—is to have eight clients per clinician. This would be in line with caseloads at the facility for civilly committed sex offenders in Wisconsin, which many of our interviewees considered to be a model program. However, the clinical director stated that clinicians at Moose Lake have sometimes had up to 25 clients on their caseloads.

When caseloads are too high, clinicians may be less able to properly document progress in client files, submit necessary paperwork to advance a client (such as referrals for polygraphs), provide individual therapy, or observe and assist clients in their daily behaviors. High caseloads may also lead to delayed assessments of clients who are not progressing due to a learning disability or other cognitive difficulty. When clinicians are overworked, those who have the most trouble or who speak the loudest may get the most attention. Clients who are well behaved and may be progressing nicely in treatment may not be noticed.

In addition, we observed weak documentation in some clinicians' files, perhaps reflecting high caseloads. Some files were missing quarterly or annual reviews of client progress in 2008, 2009, or 2010. In general, we observed that files in recent years (since 2008) tended to have much less detail than those from previous years, suggesting that clinicians either did not have time to fully

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document client behaviors or be fully aware of client behaviors relevant to treatment.

Clinicians at DOC facilities and some other civil commitment programs can receive higher pay than MSOP clinicians.

Clinical vacancies have been caused by: (1) staff turnover and (2) growth in the program, which continually creates a need for more clinicians. MSOP has had difficulty attracting and retaining clinicians for a variety of reasons. First, MSOP clinicians have a different employee classification than DOC clinicians within their union, putting them at a competitive disadvantage. Maximum annual salaries for DOC's clinicians can be up to about $10,000 more than MSOP maximum clinician salaries. Second, the federal and Wisconsin civil commitment facilities pay more than MSOP. Third, it is sometimes challenging to attract clinicians to work and live outside of the Twin Cities metropolitan area (or for clinicians' spouses to find work in these areas). Fourth, clinicians may not want to work for MSOP because of its reputation for program instability and not releasing any clients.

In addition, working at a treatment center for sex offenders can be emotionally difficult. Staff told us it is hard to treat people who are often reviled in the community. One clinician said that some staff vacancies are due to normal "burn out" that is common in many social service professions. It can be difficult to find clinicians who are willing to work with sex offenders. Inevitably, some clinicians who are hired to positions in MSOP facilities will discover that they do not want to work with this population. Despite their challenging work, the treatment staff we interviewed were committed to the work being done at MSOP and believed in clients' ability to change.

Despite these challenges, the program has recently had success in filling many clinical vacancies. However, having many new clinical staff presents its own set of difficulties, as these staff are often inexperienced. Clinical staff learn to do their job through on-the-job training and mentoring by other clinical staff. This adds to the already large workload of existing clinical staff. It also takes time for new clinicians to develop the skills of more seasoned therapists.

Due to clinician turnover, clients often have not had the benefit of consistent clinical care. It is difficult for clinicians who are new to their clients to know whether a client has improved over time or whether a learning disability, cognitive problem, or mental illness is hindering the client's treatment.

In filling clinical vacancies, we found that:

- **Since 2008, MSOP administrators have required new clinicians to have master's degrees and be licensed or licensed-eligible in contrast to past practices.**

The current administration inherited some clinical staff who had been promoted into clinical positions even though they lacked a background in therapy. For example, some clinicians were formerly security staff, with backgrounds in criminal justice. Some have only a high school diploma. The administration's focus on staffing the program with master's level clinicians should promote professionalization in the clinical area and assure that clinicians have a clinical

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background that equips them to do the intensive treatment required in the program.

Amount of Treatment

While MSOP administrators assert that every organized activity at MSOP is part of treatment, group therapy and psychoeducational modules specifically focus on delivering sex offender treatment. We examined the amount of treatment delivered to clients as shown in the schedules of the 41 clients whom we selected to review.

When comparing the amount of treatment received by clients at MSOP facilities to clients in other sex offender programs in Minnesota, we found that:

- **The amount of treatment delivered at MSOP facilities is lower than at any other adult inpatient sex offender treatment program in the state.**

As of November 2010, clients who were participating in treatment at Moose Lake received six hours of group therapy per week.[16] In addition, about half of the clients in our Moose Lake sample received psychoeducational modules for generally an hour and a half per week. Clients from the alternative program (the program for clients with cognitive disabilities located in St. Peter) received six hours of group therapy per week, plus two hours of additional psychoeducational modules.[17]

Unlike other residential sex offender treatment programs, MSOP is not required to comply with a rule requiring a minimum number of treatment hours.

MSOP delivers less treatment hours to its clients than either of the two other residential adult treatment programs in the state: the Department of Corrections (DOC) Sex Offender Treatment Program and the privately operated Alpha Human Services. With the exception of MSOP, all adult residential sex offender treatment programs in the state are governed by *Minnesota Rules* 2010, chapter 2965. The rule requires that clients in these programs receive an average of 12 hours per week of sex offender treatment in the primary phases of treatment.[18] The head of the DOC Sex Offender Treatment Program confirmed that clients in the program receive an average of 12 hours of treatment per week, including group therapy, individual therapy, psychoeducational programming, and therapeutic community meetings. Inpatient clients at Alpha Human Services receive 20.5 hours of scheduled group therapy per week in addition to at least a

[16] There was one client in our Moose Lake sample who did not receive six hours of group therapy per week. This client resided in the Young Adults unit and received additional psychoeducational modules and therapy in lieu of the entire six hours of group therapy.

[17] Clients in Phase Three in St. Peter have generally completed work needed in psychoeducational modules and therefore received six hours of group therapy, as well as programming (such as community outings and transitions group) to assist them in preparing for release.

[18] *Minnesota Rules* 2010, 2965.0150, subp. 1. The rule also applies to the joint MSOP/DOC program in the Minnesota Correctional Facility at Moose Lake.

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half an hour of individual therapy.[19] Both the DOC program and Alpha Human Services have established environments with similar therapeutic expectations as MSOP for clients to demonstrate and learn behaviors during their daily lives.

MSOP is not governed by *Minnesota Rules* 2010, chapter 2965 and is not accredited by any agency outside of DHS. MSOP is governed by a Department of Human Services administrative rule which does not specify a minimum number of treatment hours.[20] In our sample, the most sex offender treatment received by a client in the primary phase of treatment (a Moose Lake client) was eight hours and fifty minutes per week.

Clients at Moose Lake generally received between 6 and 7.5 hours of treatment per week, while DOC and a private residential facility provided more hours of treatment to their clients.

Programs operating under the DOC rule may count treatment hours differently than MSOP counts treatment hours. MSOP counts only group therapy and psychoeducational classes as part of their total treatment hours. Therefore, we specifically examined the number of hours of group therapy and psychoeducational classes Alpha Human Services and DOC deliver per week and compared that to the number of hours per week delivered at MSOP facilities. MSOP clients at Moose Lake in our sample generally received between 6 and 7.5 hours per week of group therapy and psychoeducational classes. In contrast, DOC provides between 9 and 10.5 hours per week of group therapy and psychoeducational classes.[21] Alpha Human Services delivers 8 hours per week of group therapy focusing on general therapeutic issues which affect sexual recidivism in addition to 7.5 hours per week of group therapy focusing specifically on sexual behaviors of clients. Clients at Alpha Human Services also must attend at least a half an hour of individual therapy per week. Psychoeducational classes are provided periodically on a rotating basis and are in addition to the hours of therapy described above.[22] Therefore, treatment hours at Alpha Human Services, which are comparable in type of treatment to MSOP treatment hours, total at least 16 hours per week – or more than double what MSOP offers.[23]

The "risk principle" of sex offender treatment literature suggests that the highest risk offenders should receive the highest intensity treatment. MSOP was designed to hold and treat the highest risk offenders in the state. However, it appears that offenders who are lower risk (in the DOC program or Alpha Human

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[19] Alpha Human Services' policy is to provide a minimum of 60 minutes of individual therapy per week. Due to short staffing for four months, they began providing a minimum of 30 minutes of individual therapy per week. However, some clients received far more than 60 minutes of individual therapy per week. In addition, Alpha Human Services expects to resume requiring 60 minutes of individual therapy per week in March 2011.

[20] *Minnesota Rules* 2010, 9515.3000-9515.3110.

[21] DOC counts between 1.5 and 3 hours per week of therapeutic community meetings towards the 12 hours of treatment they provide. Since MSOP does not count this type of meeting in their tally of treatment, we excluded that treatment here.

[22] We did not include hours of psychoeducational programming in the above tally because classes are not always provided. However, these classes are offered once a quarter for six to eight weeks for one and a half to two hours per week.

[23] Alpha Human Services also provides five hours of "Behavior Group," which is similar to DOC's therapeutic community meetings. We do not count these hours here because MSOP does not count this type of therapy as treatment.

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Services) receive more intensive treatment as measured by hours of sex offender treatment per week.

MSOP also has generally delivered less treatment than civil commitment programs in other states.

We also compared the amount of treatment delivered at MSOP facilities to "best practices" nationally. We found that:

- **MSOP is at the low end of the range of treatment hours considered to be best practices for sex offender civil commitment programs.**

Outside experts who have been hired annually by MSOP to evaluate the treatment program have noted that the number of treatment hours provided per week is on the low end of the range of hours provided by other facilities for civilly committed sex offenders. They have noted that other programs typically provide between 6 and 12 hours of treatment programming per week. In 2009, they recommended that MSOP conform to best practices by increasing the number of treatment hours provided. It has been difficult for MSOP to schedule treatment hours due to clinical staffing shortages. In 2009, psychoeducational modules at Moose Lake were completely suspended for three quarters due to staff vacancies. While MSOP has increased weekly treatment hours for some clients from 6 hours to 7.5, the amount of treatment still remains on the low end of the spectrum as outlined by these experts. MSOP treatment staff told us that they anticipate increasing treatment hours once the Moose Lake facility is fully staffed.

We also looked at the percentage of clients who were actually receiving sex offender treatment. While about 80 percent of MSOP clients are participating in the treatment program, only about one-fourth are receiving treatment specifically related to sexual offenses. As of June 30, 2010, about 50 percent of MSOP clients are in Phase One of the treatment program.[24] Phase One of the program does not focus directly on the behaviors that led to offenders' commitments. Rather, Phase One is focused on preparing clients for treatment by asking clients to demonstrate that they can follow rules and learn how to participate in treatment groups. Phase One treatment does not explore the reason for offenders' sexual offending or help offenders develop tools to prevent offending.[25]

Some clients may be "stuck" in Phase One because they lack motivation. However, some clients may also be in Phase One because the program has not been sufficiently staffed or because the environment at Moose Lake has not promoted positive treatment participation. Many clients who are in Phase One have been at an MSOP facility for years and have participated in a lot of sex offender specific treatment at MSOP previously. Some of these clients have expressed frustration that they are no longer in treatment specifically focused on their sexual offenses.

[24] With a growing population, there is also a constant influx into Phase One.

[25] MSOP administration noted that addressing behaviors that interfere with treatment is standard in the early stages of contemporary sex offender treatment programs.

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We also looked at client schedules to determine what they do with their time. We found that:

- **Most of Moose Lake clients' time is unstructured.**

As discussed above, treatment hours are limited partly by the fact that there have been persistent clinical vacancies. In addition, there are limited work opportunities for clients. Therefore, clients who do not participate in treatment are allowed to work only up to eight hours per two-week pay period; Phase One clients can work up to 14 hours; Phase Two clients can work up to 24 hours; and Phase 3 clients can work up to 30 hours. Few, if any, clients are scheduled the maximum amount of work hours. One clinician at Moose Lake expressed concern that clients do not even approach having a full forty hours per week of scheduled activity. In our file review, one client participating in treatment documented that he had watched 77 hours of television in one week in 2010. While recreation is available to clients from 8:00 a.m. to 9:00 p.m., client schedules showed very few scheduled recreation activities. The use of the gymnasium in Moose Lake is very limited by its current use as a dining hall.[26] For Moose Lake clients whose files we reviewed, weekly structured client time (including treatment, scheduled recreation, work, and education) ranged between 0 and 22.5 hours. In contrast, our file reviews showed that, prior to 2004, some clients complained about having too many classes, too many groups, and too many assignments.

Current clients at Moose Lake appear to have less time in treatment and scheduled activities than clients at MSOP facilities before 2004.

RECOMMENDATION

The Department of Human Services should require MSOP to provide more treatment hours per week.

We believe that high risk sex offenders held at MSOP facilities should receive at least as much treatment as some lower risk offenders receive at other residential sex offender treatment programs in the state. DHS should consider promulgating a rule requiring a minimum number of treatment hours to assure that MSOP clients receive as much treatment as they would receive at other residential programs. Delivering additional treatment hours at MSOP facilities will be challenging while staffing vacancies remain.

The Therapeutic Environment

Many sex offenders have antisocial attitudes, poor interpersonal skills, and distorted thinking about others that contributed to their sexual offenses. To create behavior change that will reduce clients' risk of reoffending, MSOP is designed to be a 24-hour intensive treatment environment. While formal treatment takes place in group therapy and psychoeducational modules, clients receive behavioral guidance in education classes, work programs, recreational settings, and living units. Clients are observed in all aspects of daily living to

[26] Construction due to be completed in 2012 will include a dining hall.

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assess whether they apply what they have learned in treatment to their daily behaviors.

MSOP is designed to be a 24-hour treatment environment, but faces many challenges in creating an atmosphere conducive to treatment.

We examined the therapeutic environment at MSOP facilities and found that:

- **Historically and currently, the program has struggled to create an environment that fosters client rehabilitation.**

Outside advocates and experts, MSOP clients, and some MSOP staff have complained that, historically and currently: (1) some MSOP staff held disrespectful, negative, punitive, and untherapeutic attitudes towards clients; and (2) that the culture at the facilities was counter-therapeutic. In our review of the records of clients who had been in the program for at least four years, we found evidence that clients were sometimes treated with suspicion, their reasonable frustrations were considered treatment problems, and they were sometimes punished for behavior that appeared to be normal. Under some past MSOP administrations, the program focused so much on client behaviors that any infraction could result in a client failing to progress or being sent backwards in treatment. The program still struggles with staff who are overly suspicious of clients or who expect impossible perfection. This can make progress in treatment difficult.

In the sections below, we address several additional specific issues that have contributed to the challenge of creating and maintaining a therapeutic environment. These include: (1) the physical design of the facilities, (2) the balance between security and therapy, (3) changes in the role of MSOP security counselors, and (4) the difficulty of motivating civilly committed offenders to meaningfully participate in treatment.

Physical Design of Moose Lake Facilities

The physical environment at MSOP facilities also affects the therapeutic environment. We found that:

- **The physical structure of Complex One at Moose Lake has made it difficult to create a therapeutic environment.**

Creating a therapeutic environment has been challenging because the newly constructed "Complex One" was not designed primarily for therapeutic goals. The structure has two 98-bed living units and three 68-bed units. This design is more typical of correctional facilities and assures that the building is safe and the highest number of clients can be efficiently monitored with the smallest number of staff. However, these units are much larger than the other Moose Lake building units, all units in St. Peter, and the units of the joint DOC/MSOP facility located in the Moose Lake Correctional Facility. In addition, units in Complex One are larger than any unit at the Sand Ridge facility in Wisconsin. Small units are important because behaviors can more readily be observed and addressed by staff. Also, it is easier to create a culture among clients of holding each other accountable when units are small.

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In addition, Complex One units lack any clinician offices. Clinicians for these units are housed outside the living units in a "bullpen." The executive clinical director feels that housing clinicians off the units undermines the residential nature of the treatment and follows a less intensive outpatient model which requires clinicians to come to the unit to do treatment.

MSOP's executive clinical director told us that creating a therapeutic climate on such large units is very challenging but still possible. Administrators said that, with renovations due to be completed in 2012, they will be able to create a more therapeutic environment by placing clinician offices on the units. Despite acknowledging that the large units in Complex One are less than ideal for creating therapeutic environments, MSOP is currently planning an expansion which would create a second building identical to Complex One.

RECOMMENDATION

In evaluating designs for the construction of new living units for MSOP, the Legislature and DHS should consider the tradeoffs between the efficiency of staffing large units and the effect of larger units on the therapeutic environment.

MSOP was able to decrease costs partly because of increased efficiency of staffing in Complex One. Large units constructed with clear lines of sight allow the program to use fewer security staff to monitor more clients. However, as discussed above, using such large units presents difficulties in creating and maintaining an environment that is suitable for promoting therapeutic change. Both the security benefits and the therapeutic drawbacks should be considered as MSOP evaluates its options for additional bed space.

The Security/Therapy Balance

Current MSOP administrators inherited a program with significant safety and security issues.

Current administrators told us that MSOP devoted substantial resources to safety and security concerns prior to 2008 due to staff assaults and two different escapes. In addition, some practices at MSOP made security difficult. For example, clients were allowed so much property that it could take two staff members eight hours to search a single room. Clients were also allowed to order food from outside vendors, potentially allowing contraband to be smuggled inside the food. As a result, the current administration took immediate actions to address these safety and security concerns.

We evaluated the current administration's response to previous conditions in the program. We found that:

- **Starting in 2008, MSOP administrators took significant steps to address safety and security weaknesses at MSOP facilities and develop written policies.**

Administrators made the perimeter more secure by changing the way food was distributed to clients. They limited the amount of property clients could have,

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established a trained team of first responders, wrote protocols for responding to emergencies, limited client movement outside of the living units, and trained security staff in the use of chemical irritants.

In addition, they decided that client living units were overstaffed for the purposes of security and reduced security staffing on the largest living units from 16 security staff per shift to 2 staff per shift. MSOP's new management team believed that a reduction in security staff could be made without sacrificing staff and client safety. For example, by locking clients in their rooms at night and establishing a team of first responders, administrators concluded they no longer needed as many security staff.

Current administrators told us that when they first took over, MSOP did not have consistent or organized written rules and policies. The absence of written policies prior to 2008 resulted in inconsistency. Staff on each unit developed their own rules and there were no policies to hold staff accountable or maintain a therapeutic environment. The current administration wrote many new policies in cases where no policy existed before or where generic DHS policies had previously been used. One of the first tasks of the current administration was to establish MSOP-specific policies and procedures.

Some security changes made by the current MSOP administration have adversely affected the therapeutic environment.

We found that:

- **While the current MSOP administration made needed security changes, some security changes have adversely affected the therapeutic environment, particularly at Moose Lake.**

In our interviews, we heard widespread agreement among clinicians, clients, outside advocates, experts, and some MSOP administrators that the program has recently focused on security to the detriment of therapy. In the absence of clinical leadership when the current administration took over MSOP in 2008, some policies were put into place without adequate consideration for the effect those policies would have upon the therapeutic environment.

Clinicians and clients described how isolated incidents resulted in general policies which took away privileges from all clients. For example, MSOP prohibited clients from sharing food with each other. Because of concerns about inappropriate touching, clients are no longer allowed to shake hands with each other or staff. Clients who were once allowed to move within the facility on their own schedule are now required to move together at specifically set times. Clinicians told us that these types of restrictions undermined their efforts to promote client independence and prosocial behaviors. Also, they said the new rules and policies contributed to an "us versus them" attitude between clients and staff.

Program managers now recognize that some security changes they thought were necessary in 2008 may be out of balance with therapeutic concerns and told us they are considering changes. A policy review committee established in September 2008 includes the executive clinical director and other clinical leaders to ensure consideration of treatment and the therapeutic environment during the adoption of program policies. The executive clinical director stated that many

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security policies established early on in the current administration's tenure were necessary to create a safe environment for treatment.

Role of Security Counselors

The role of security counselors has changed significantly.

Perhaps the biggest change to the therapeutic environment was the administration's decision to dramatically cut security staff in 2008. Security staff at MSOP facilities are called "security counselors" as a reflection of the dual role they hold in both assuring security in the facility and helping clients make behavioral change in their daily lives. Security counselors are taught to observe client behavior and report behaviors to clinical staff. They are also supposed to model good behavior and help clients solve problems.

Security counselors and clinical staff told us that security staffing levels are not sufficient to perform the therapeutic and observational functions they once had. In the past, the largest living units had up to 16 security counselors per unit. These staff documented client behaviors in clients' records. They also helped clients complete treatment assignments, intervened to address client behaviors in a therapeutic manner, listened to clients' problems and concerns, and checked in with clients regarding their quarterly treatment goals. Security counselors participated in MSOP quarterly meetings regarding client progress and also sat in on treatment groups. Other secure residential facilities, such as the Minnesota Security Hospital, the Leo Hoffman Center (for juveniles with sex offending histories), and the Sand Ridge facility in Wisconsin, also utilize security counselors as a way to maintain a therapeutic presence in living units.

Around-the-clock behavioral information is essential for MSOP to be intensive enough to create behavior change. This is especially true because MSOP has many clients with high psychopathy or who are talented at appearing good while behaving badly. Since clinicians work Mondays through Fridays from 8:00 a.m. to 4:30 p.m., using security staff as part of the treatment team allows therapeutic monitoring of clients when clinicians are not in the facility. Input from security counselors also provides clinicians much needed information about whether clients have internalized treatment concepts.

While security counselors are no longer allowed to write in clients' records or sit in on treatment groups, they are expected to report relevant client behaviors to clinicians during unit meetings at the beginning and end of each day. In addition, they are expected to use a communication log to document client behavior. However:

- **Clinicians we interviewed do not believe that the current level of communication and security counselor staffing is sufficient for them to get all the relevant information needed regarding client behavior.**

In our review of clients' records, there was noticeably less information about client behavior in the most recent years than in earlier years. In the past, many behaviors were noted by security and then referenced by clinicians in their quarterly and annual reviews of progress; more recent reviews were less specific and rarely referenced these behaviors. Lack of documentation in client records does not necessarily mean that clinicians did not take those behaviors into

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consideration when making assessments of clients. However, we believe that when such information is absent from the chart, it is hard for clinicians with very high caseloads to remember and apply what they have heard from security counselors in making assessments of client progress.

Outside experts hired by MSOP to evaluate their treatment program commented in past years on the important role that security counselors played in assisting clients. The most recent evaluation stated that these favorable therapeutic components had been reduced with the reduction of security counselor staff, especially on larger units, and that the program needed to find a way to compensate for the loss of these staff.

We recognize that there are legitimate reasons for limiting the relationships between security and clients. When clients and security staff become too close, it can result in introduction of contraband into the facility and inappropriate relationships between staff and clients. In addition, our file review suggested that some security counselors documented irrelevant behaviors of clients and were overly concerned regarding minor violations.

The executive clinical director stated that security counselors need more clinical training to know what to document, and that she does not believe that it is proper for security staff to sit in on group therapy sessions. She also stated that filling all clinical vacancies and locating clinician offices in living units will help improve the therapeutic environment. Finally, MSOP will be converting its documentation systems to an electronic system which will make information sharing easier, more accessible, and more centralized.

RECOMMENDATION

As clinician positions become fully staffed and clinician offices are located in living units, MSOP should closely monitor whether staffing in living units is sufficient to improve the therapeutic environment.

Changing the role of security counselors and reducing their staffing levels has affected how treatment is delivered.

Reducing security staffing levels and changing the role of security staff has affected how treatment is delivered, how information is collected on clients, and the therapeutic environment in MSOP facilities. Since these changes took place, the Moose Lake facility has not been fully staffed with clinicians. In addition, remodeling living units to provide clinician offices in the units has not yet been completed. It is too early to tell whether filling clinical staff vacancies at Moose Lake and putting clinician offices in living units will improve the therapeutic environment in the facility. However, MSOP should monitor whether the changes they have made improve the therapeutic environment at the Moose Lake facility.

Client Motivation

Client motivation is a prerequisite to successful and meaningful treatment participation. Clients may not challenge thinking patterns and behaviors they have held for a lifetime without feeling that the program is there to help them make those changes. However, we found:

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- **Lack of client motivation has been a barrier to progression in treatment.**

Client motivation is key to successful treatment participation.

In our focus groups, clients at Moose Lake expressed a great amount of hopelessness regarding the possibility of their release. Clients cited a 2003 executive order prohibiting the release of anyone from MSOP without a court order as evidence that the program does not truly seek to rehabilitate them. They described living at Moose Lake as so stressful under the new administration that some have sought revocation of their supervision so that they may return to correctional facilities where they at least saw people being released. Many clients also struggled with motivation because of the frequent changes in the treatment programming and in the MSOP administration.

MSOP has taken steps to address client motivation. The former Moose Lake clinical director conducted a program-wide training on motivational interviewing, teaching all staff with clinical interactions methods of reaching out to clients to encourage them to participate more fully in treatment. Motivational interviewing is also now a part of clinicians' orientation and continuing training at MSOP. The executive clinical director stated that the motivational interviewing training was good for bringing more empathy to the program and a start in balancing therapeutic and security perspectives.

Perhaps the most important motivator for clients is the prospect of release back to the community. We found that:

- **The current administration has taken steps toward provisionally discharging some clients.**

MSOP administrators hope that releases from the program will encourage clients to work hard in treatment and combat some hopelessness. Under the current administration, MSOP has supported six client transfers to Community Preparation Services (CPS) residences located outside of the secure perimeter. MSOP has also opened a second CPS residence outside of the secure perimeter. The current administration has re-evaluated all Phase Three clients and administered detailed personality tests to assure that those clients nearing release have truly internalized their treatment. MSOP has supported six petitions to the Special Review Board for clients to transfer from the MSOP Supervised Integration program within the perimeter to the CPS program. MSOP has also supported two petitions for provisional discharge of CPS clients. In order to help motivate both clients and clinicians at Moose Lake, the administration brought some CPS clients to Moose Lake to talk about the treatment program at St. Peter and the reintegration program.

While we found that the administration is taking client releases seriously, it is important to note that:

- **Only 7 percent of MSOP clients are in the last of the program's three phases of treatment.**

As of February 1, 2011, there were 7 residents at CPS and another 30 clients in Phase Three of treatment. Clinicians we interviewed at St. Peter expressed

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concern that there was a "clogged drain" in Moose Lake, but the executive clinical director stated that there were not clients in Moose Lake who were ready to move to St. Peter. She noted that changing clients' behaviors can take many years. To make progress in treatment and be considered for release, she said clients need to demonstrate that they have changed.

However, some clients are unwilling to change and are not participating in treatment. About 20 percent of MSOP clients do not participate in treatment. This is consistent with the levels of nonparticipation at other civil commitment programs nationally. Even in Wisconsin, where clients are routinely released, some clients are pessimistic about treatment or refuse to participate.

We recognize that some clients will never be able to complete the treatment program because they are unwilling or unable to change their behaviors. However, for clients who want to change, MSOP should consider additional ways to provide motivation.

Few privileges exist to motivate Moose Lake clients.

For example, there are few privileges at Moose Lake to motivate clients, and some clients refuse to believe that clients in St. Peter are allowed to live outside the secure perimeter or go on outings off campus. Currently, the only motivating privileges for Moose Lake clients are being eligible for additional work hours and having the chance to have their own room in a smaller unit when they reach Phase Two of treatment. Clients at Moose Lake formerly had incremental privileges associated with their treatment participation and progress, but new rules have curtailed privileges such as ordering food from outside or using the barbecue grill. Officials at the Sand Ridge facility in Wisconsin told us that privileges, however small, are essential to keeping clients motivated. Moose Lake clinicians also told us that they viewed privileges as an important therapeutic tool.

RECOMMENDATION

MSOP should consider creating an incremental privilege system for clients in the early phases of treatment in order to increase client motivation.

Increasing client motivation to participate in treatment is essential to helping clients progress through the treatment program. From a security standpoint, it may be difficult to monitor clients with different privilege levels. However, in order to balance therapeutic and security concerns as well as to encourage clients to participate in treatment, we believe that MSOP should consider using some privileges to motivate clients.

ASSESSMENTS OF NEED AND TREATMENT PROGRESS

Sex offender treatment literature generally suggests that treatment should address areas which are linked to reoffending for each individual (the need principle). MSOP identifies each client's "dynamic" risk factors for recidivism and seeks to address these factors in each phase of treatment. Dynamic risk factors are those

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risk factors which are changeable by the client. For example, many offenders have hostility toward women or emotionally identify with children.

In this section, we discuss how MSOP assesses the changeable risk factors that clients possess, as well as how MSOP evaluates clients' progress in addressing these risk factors. Whether clients have clear goals and expectations in treatment affects how well they can progress and complete the treatment program.

Treatment Assessments and Planning

Upon admission to MSOP, clinicians assess which dynamic risk factors affect the client. Individual treatment plans are prepared showing which dynamic risk factors the client needs to address to reduce their risk of offense and how those risk factors will be addressed. Clients' progress is reviewed quarterly by the client's primary therapist and that therapist's clinical supervisor. A more thorough review with the client's entire treatment team is performed annually. This annual review is used to create annual individual treatment plans.

We examined whether treatment plans and reviews were individualized and specific enough to give meaningful information about treatment expectations. We found that:

- **MSOP treatment plans and reviews are individualized and set meaningful goals, but do not provide the level of detail as past plans and reviews, nor are they as explicit about how clients can advance in treatment.**

Treatment goals are individualized in that each offender is expected to make behavioral changes related to the specific dynamic risk factors that have been identified for him. Treatment plans and quarterly reviews make specific references to the challenges individual clients face and their successes in treatment. However, it is not always clear from these reviews what the client needs to do to advance in treatment, especially when the client is meeting all their goals and doing well in treatment. Clinicians also do not always explain or discuss how they came to their conclusions about client progress.

Some periodic reviews of client progress contained insufficient detail.

The amount of detail included in both annual and quarterly reviews varied among clinicians. Some clinicians made summary conclusions without providing evidence or specific events that led them to their conclusions. Others provided examples of things that the client did or said that supported their conclusions about the client's progress. For example, in one file we reviewed, the clinician stated only that the client "can deploy prosocial problem solving skills in place of emotion focused or avoidant responses to stress or problems." Another client whose file we reviewed also did well in the area of prosocial problem solving. However, the clinicians writing the review discussed specific examples of how the way he solved specific problems over the course of the quarter demonstrated this skill.

We believe that detailed feedback, regarding both positive and negative behaviors, is more helpful for clients. It is also helpful to outside reviewers, such

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as the Special Review Board, county attorneys, defense attorneys, and county social workers. The detail provided in some reviews provides more specific guidance on what behaviors a client needs to continue or to change.

Reviews of client progress under past administrations contained far more detail.

Quarterly reviews and treatment plans written under some past administrations often involved much more specific detail about client behaviors that related to his goals and his progress in treatment. In addition, reviews included reports from all staff including security staff, recreation staff, medical staff, vocational staff, and clinical staff. Accordingly, observations related to treatment goals were less likely to be confined to observations from treatment groups.

The executive clinical director acknowledged that past plans and reviews contained more and diverse specific detail. She noted that the program did not deliver treatment for eight to ten working days between trimesters so that staff could do all the documentation required. This resulted in the program not delivering treatment for one month out of the year, which she found unacceptable. In addition, she pointed out that she and the facility clinical directors made a decision in July 2009 to make quarterly reviews less detailed and formal than they had been in the past. Instead, they chose to make annual reviews a more comprehensive review process.

Based on our observations, annual reviews conducted since the policy changed in July 2009 do give more information than quarterly reviews. However, they still often rely heavily on summary statements without providing specific details regarding why a client advanced (or not) and how he was meeting his treatment expectations. In addition, while annual reviews involve the entire treatment team, they still do not reflect the input of vocational, recreational, education, and security staff to the extent that past reviews did. These staff are ostensibly part of the client's treatment in the inpatient environment at MSOP, but they are not part of the treatment review process that they once were.

Some of the differences between the level of detail in treatment plans and reviews may be due to being understaffed and having newer, less seasoned clinicians who are continually being hired to keep up with the program's growth.

RECOMMENDATION

MSOP should train and supervise clinical staff to assure that quarterly and annual reviews contain enough specific detail to provide meaningful feedback to clients and others regarding treatment progress.

Lack of detail in reviews of client progress can be a result of clinicians being overworked. In addition, MSOP may not currently have sufficient clinical supervisors to assure that all clinicians are consistently documenting sufficient relevant detail to be helpful to clients, outside reviewers of client progress, and clinicians who may treat clients in the future. As MSOP continues to hire new clinical staff as well as clinical supervisors, the program should assure that staff are trained to write reviews with a meaningful amount of detail. The program should also monitor whether information on client behavior is being effectively

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shared between clinical staff and security, vocation, education, and recreation staff.

The "Matrix" and Measures of Progress

A "treatment matrix" is the main tool used by MSOP to assess clients' treatment needs and progress. This matrix was developed by MSOP, and clinicians began using it in the spring of 2009. As shown in Table 3.1, the treatment matrix focuses on ten behavioral areas which are linked to dynamic risk factors identified in the recidivism literature.[27] The matrix outlines specific behaviors that clients must demonstrate to address their risk factors and progress through treatment. Table 3.2 shows an example of one behavioral area and the specific expectations for each phase of treatment. In our interviews, we found that:

- **MSOP's treatment matrix is highly regarded by MSOP clinicians and professionals outside of MSOP.**

MSOP clinicians said the matrix is empirically sound and provides clients with specific behavioral targets. The matrix outlines a clear progression in treatment for clients which did not exist before 2010. Outside experts hired by MSOP found that the matrix was clearly linked to empirically based risk factors that clients can change through treatment. Officials at the Sand Ridge facility in Wisconsin told us the matrix closely resembles the tool they use to evaluate clients' progress in treatment.

While the matrix is clearly rooted in the literature,[28] we found that:

- **Treatment matrix standards are somewhat undefined and overly subjective.**

The main tool used by MSOP to assess treatment progress needs to be applied more consistently.

MSOP clinicians were trained on the matrix when it was introduced in the spring of 2009. However, many clinicians told us the matrix was not uniformly applied and suggested that MSOP set standards for interpreting the tool. Some clinicians stated that some MSOP therapists were too rigid in their interpretations, requiring impossible perfection from clients, while others imposed a more lenient standard. Clinicians and outside reviewers alike felt that the program needs to take actions to improve consistency between clinicians in applying the matrix. Outside reviewers recommended developing a treatment manual or providing further training in order to establish more objective standards for interpreting client progress according to the matrix. The MSOP clinical director stated she is working on a treatment manual which will include a clinician guide on the matrix.

[27] See Karl Hanson and Kelly Morton-Bourgon, "The Characteristics of Persistent Sexual Offenders: A Meta-Analysis of Recidivism Studies" 12 no. 6 (2005): 1154-1163; and Karl Hanson, "Risk Assessment" (Beaverton, OR: Association for the Treatment of Sexual Abusers, 2000).

[28] *Ibid.*

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Table 3.1: Dynamic Risk Factors and Their Corresponding Behavioral Areas on MSOP's Treatment Matrix

Treatment Matrix Behavioral Area	Dynamic Risk Factors
Group Behavior	• Resistance to rules or 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 • Deviant sexual interests • Sexualized coping
Thinking Errors	• Offense supportive attitudes • General hostility • Hostility toward women • Antisocial attitudes and behavior
Prosocial 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 or supervision • Antisocial attitudes and behavior
Sexual Functioning	• Sexual preoccupation • Deviant sexual interests • Sexualized coping
Productive Use of Time	• Unstable Work History

SOURCE: *Minnesota Sex Offender Program (MSOP) Program Manual*, (St. Paul, September 2010), 23-24.

The current clinical director has also introduced some objective measures of treatment progress.

While the matrix is the main tool used to assess client progress, the current executive clinical director has also introduced the regular use of objective measures of sexual interest and behavioral compliance. These objective measures are commonly used in other sex offender treatment programs. They include the penile plesmograph (PPG), polygraph testing, and the Able assessment of sexual interest. The PPG and Able tests measure clients' sexual interests. The polygraph is used to determine whether clients are telling the truth about what they are doing in treatment. For example, the tester may ask the client if he has broken any facility rules. In addition, clinicians record elements of client behavior in therapy groups. For example, therapists track the number of times per quarter that a client references their offense pattern in group.

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Table 3.2: Sample Matrix Behavioral Area (Emotional Regulation)

Phase	Treatment Goals
Phase One	(a) Express emotional responses proportionate to situations (neither excessive nor flattened).
	(b) Maintain safe, responsible behavior when experiencing strong emotions.
	(c) Recover from difficult or intense emotions appropriately, asking for help as needed (rather than shutting down or thinking about them angrily for a long time).
Phase Two	(a) Develop a healthy awareness of emotions (neither denying nor suppressing them).
	(b) Expand range and repertoire of emotional responses.
	(c) Refrain from dwelling on emotions in a way that interferes with healthy functioning.
Phase Three	(a) Increase self-reliance when it comes to managing emotional responses.
	(b) Manage lifestyle and cope with events in a way that demonstrates a healthy range of appropriate emotions.
	(c) Recognize the link between dysfunctional emotional reactions and activation of maladaptive schemas.
	(d) When maladaptive schemas have been triggered, use effective coping strategies to restore healthy emotional regulation relatively rapidly and without self-injurious, hostile, or impulsive behavior.
	(e) Apply mindfulness skills to assist in regulating emotions and focusing attention.
	(f) Practice and generalize emotional regulation skills to environments that offer more freedom, choices and different temptations.

SOURCE: *Minnesota Sex Offender Program (MSOP) Program Manual*, (St. Paul, September 2010), 21.

RECOMMENDATION

MSOP should complete the treatment manual. This manual should include clear clinical guidance on the interpretation of the matrix.

With many clinical and supervisory vacancies and turnover, the program cannot rely solely on mentoring and clinical supervision to assure that the matrix is consistently applied. Clinical judgment of clients' behavior change will always be somewhat subjective. However, the program can establish clearer parameters for client behavior in each phase. Completing the treatment manual and including clear guidance on matrix terms and phase expectations should help create consistency in clinical decisions.

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CLIENTS WITH SPECIAL NEEDS

MSOP is intended to serve the needs of any individual who is committed as a sexually dangerous person or sexual psychopathic personality. Whether the program can meet the unique needs of its clients affects how well clients can progress through treatment. To meet the diverse needs of MSOP clients, we found that:

- **The program has created specialized living units and programs.**

As shown in Table 3.3, MSOP has created specialty units for clients needing assisted living care, clients who have disruptive or threatening behavior, clients with high psychopathy, clients with significant mental health diagnoses, clients

Table 3.3: MSOP Programming Units

Programming Unit	Description of Activities
Admissions	Clients newly admitted to MSOP and/or going through commitment proceedings. Clients participate in assessments required by licensing.
Assisted Living Unit	Clients who are medically compromised to the extent of requiring specialized care.
Behavior Therapy Unit	Clients who demonstrate behaviors that are disruptive to the general population and/or affect the safety of the facility (i.e., assaults on staff/peers, thefts, predatory-type behaviors, etc.) are treated in this unit with the goal of mainstreaming once the interfering behaviors have been successfully addressed.
Corrective Thinking Unit	Clients with high and very high levels of psychopathic traits. Traits include: Grandiosity, instrumental emotions, impulsivity, need to dominate, callousness, irresponsibility, conning/deception, not accountable, belligerent, and lack of sustained effort.
Skill Building Unit	Clients with significant mental health diagnoses, Axis I diagnoses that do not meet the requirements for a transfer to the Minnesota Security Hospital, and/or significant personality disorders that result in persistent emotional instability and/or potential self harm.
Therapeutic Concepts Unit	Clients actively choosing not to participate in sexual offender specific programming.
Young Adult Unit	Clients who are between the ages of 18 and 25 and do not meet criteria for the Alternative Program or CTU programming.
Alternative Programming	The alternative program in St. Peter currently houses clients who have "compromised executive functioning" and who could not be successful in the conventional programming track. Phases One, Two, and Three for the alternative program and the reintegration stages of treatment are all based in St. Peter. Alternative program clients address the same matrix factors as conventional clients, though approaches to treatment differ in particular ways to ensure needs are effectively addressed.

SOURCE: *Minnesota Sex Offender Program (MSOP) Program Manual*, (St. Paul, September 2010), 31.

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who are 25 years or younger, and clients with cognitive difficulties or with low IQs. In addition, the program has conventional treatment units where most clients receive treatment. Because of the limitations of our sample size for our file review, we were unable to specifically evaluate treatment on specialty units, with the exception of the alternative program.

Generally in our file reviews and interviews, we found that there were concerns that some clients with cognitive deficits and those with psychiatric issues did not have their needs met by the program. In this section, we first discuss clients in the alternative program who are very low functioning. We next discuss higher functioning clients who have some cognitive deficits but are not being treated in the alternative program. Finally, we discuss the availability of psychiatric care in MSOP facilities.

Clients with Cognitive Deficits

There are three groups of clients at MSOP who have some cognitive deficits which may affect their treatment progress. Some clients are diagnosed as mentally retarded due to having IQs less than 70 or other profound deficits in their cognitive functioning. Prior to their civil commitment, these lowest functioning clients likely did not ever live independently or have a job. The second group of clients is higher functioning and often has IQs between 71 and 80. These two groups of clients have been found by MSOP clinicians to have compromised executive functioning, as evidenced by low IQs, profound learning disabilities, traumatic brain injury, or neurological impairment. Cognitive difficulties make it difficult for these clients to succeed in conventional programming. These two groups of clients are treated in the alternative program.

A final group of clients with cognitive deficits is higher functioning than alternative program clients, but still struggles with low intelligence, learning disabilities, memory problems, or other cognitive deficits that can affect their ability to do treatment. These clients are in the conventional treatment program in Moose Lake and St. Peter.

The Alternative Program

MSOP's lowest functioning clients may not be able to complete the treatment program.

The alternative program is located in a MSOP building on the St. Peter campus. Alternative program treatment follows the same "treatment matrix" as conventional MSOP treatment and clients advance through the same three phases of treatment. As of May 2010, there were 98 clients in the alternative program. Figure 3.3 shows alternative program clients by phase of treatment.

We evaluated how the alternative program meets the needs of the two groups of lowest functioning MSOP clients it serves. We found that:

- **The lowest functioning alternative program clients may not have the cognitive skills to complete the MSOP treatment program.**

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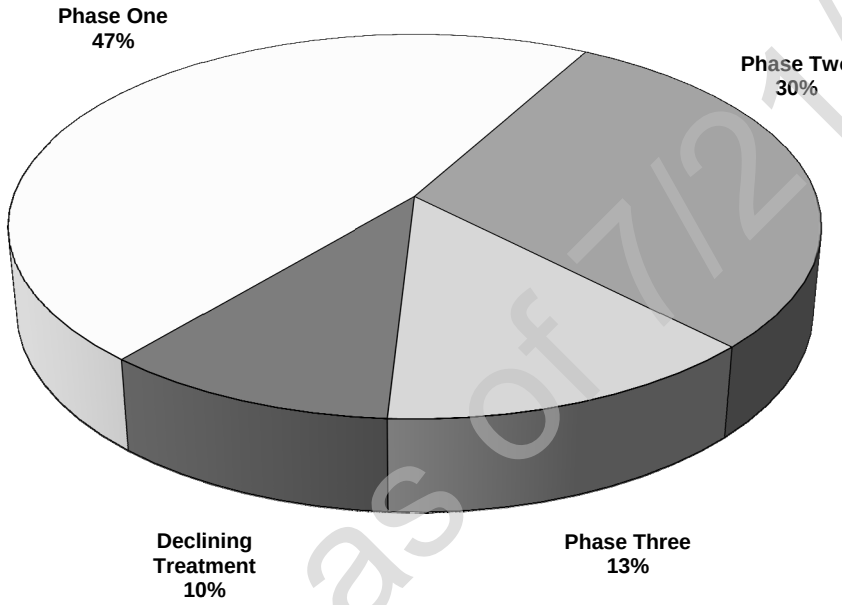
Figure 3.3: Alternative Program Client Population by Treatment Phase, 2010



NOTE: Figure shows alternative program clients by phase as of May 20, 2010.

SOURCE: Minnesota Sex Offender Program.

Historically, civilly committed sex offenders who were diagnosed as mentally retarded were sent by MSOP to a separate DHS treatment program called Special Needs Services. This program is designed specifically for low functioning, cognitively impaired persons with sexually dangerous behavior. Some MSOP clients who were sent to Special Needs Services were assessed by that program to not have the ability to complete a cognitively based treatment program. Special Needs Services treated these clients to the extent that they could be treated.

The MSOP administration separated from DHS's State Operated Services division in 2008, and low functioning MSOP clients who had been treated at Special Needs Services were moved back to MSOP in the newly created alternative program. The decision to move these clients back to MSOP was made without executive level clinical input. The decision was made by the

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MSOP executive director during a time when there was neither an executive clinical director for the program nor a clinical director on the St. Peter campus.[29]

These lowest functioning alternative program clients are now expected to complete the same, cognitively based treatment program that all MSOP clients are expected to complete. While the alternative program provides some support to help clients learn and retain treatment concepts, alternative program clients are expected to complete all three phases of treatment and master all aspects of the treatment matrix. In order to complete treatment, clients must be able to understand their own thinking patterns and sustain changes in behavior and thinking that could lead to reoffending. As past assessments of MSOP clients treated at Special Needs Services show, some current alternative program clients are not cognitively able to complete MSOP treatment.

The executive clinical director of MSOP stated that she is considering supporting provisional discharge or transfer to another treatment setting for clients in the alternative program who have been assessed to have learned the most they can from sex offender treatment. The program is currently assessing the cognitive function of some clients. The executive clinical director believes that there are some clients in the program nearing the point where they can learn no more from MSOP treatment.

While some alternative program clients cannot complete the program, these clients can be assisted to learn certain parts of the treatment program. In addition, some higher functioning alternative program clients have the cognitive ability to complete MSOP treatment in its entirety. To assist both these groups of clients, the alternative program uses treatment tools specifically designed to help those with cognitive deficits understand treatment concepts and expectations.

These tools include: pictorial representations to help clients understand their feelings, schedules, individualized treatment plans, and risk factors; art therapy; shorter group therapy meetings to accommodate the shorter attention span of some clients; and cue cards to help clients manage their risk factors. The program recently created a relaxation room which provides an opportunity for alternative program clients to calm themselves in a quiet environment. The schedules of alternative program clients appear to be more structured than those of conventional program clients, with more activities and classes regularly scheduled. The St. Peter clinical director is also working on developing an alternative matrix which uses language that is easier for alternative program clients to understand.

Some alternative program clients are close to: (1) completing their treatment or (2) being determined to have received the maximum benefit they can receive from treatment. However, we found that:

[29] MSOP management stated that this decision was made in part to protect clients from mentally ill and dangerous clients who were also being treated at SNS as well as to consolidate all civilly committed sex offenders at MSOP. MSOP management also expressed concern that SNS did not provide adequate sex offender treatment to MSOP clients who were placed there.

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Currently, there is no clear release path for low functioning MSOP clients.

- **The program has not yet developed and implemented an alternative release path for low functioning alternative program clients.**

The release path established by MSOP consists of a client first moving to the CPS facility outside of the secure perimeter and then being provisionally discharged to a halfway house in the community. However, the release path for some alternative program clients will probably have to be very different since many of these clients will never be able to live independently in the community.

Several clinicians at St. Peter expressed concern that program officials have focused on releasing conventional program clients, but have not developed suitable release plans for some alternative program clients. Some of the lowest functioning alternative program clients will need lifelong support, both with daily living and with continuing to apply the treatment concepts they have learned. However, few group homes exist that would accept these clients and be able to help them adhere to their relapse prevention plans. MSOP administrators acknowledge that they face unique difficulties in releasing these developmentally disabled sex offenders from the program.

In addition, we found that:

- **Some low functioning alternative program clients likely do not need the same level of security as other MSOP clients.**

Some low functioning clients do not need to be in a high security facility, but will continue to need support with treatment and daily living skills.

We conducted a focus group with alternative program clients who were previously in Special Needs Services, and we also reviewed several clients' Special Needs Services files and alternative program files. We learned that many of these clients had successfully managed significantly more freedoms and privileges at Special Needs Services than they are currently allowed at MSOP facilities. For example, these clients had been allowed use of the Minnesota Security Hospital pool and had taken supervised on-campus walks. These are privileges now reserved for clients in Phase Three of MSOP.

Security at MSOP is designed to contain clients who are highly intelligent criminals. Although alternative program clients have also committed criminal offenses, some of these clients likely do not have the planning and reasoning ability to get beyond basic security measures. One clinician at MSOP stated that she felt that some clients could be managed without razor wire by simply placing alarms on the windows so that the clients knew they should not leave.

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RECOMMENDATIONS

MSOP should develop and implement a plan for identifying when certain low functioning alternative program clients who are not cognitively able to complete treatment can be managed in a less restrictive setting. MSOP should petition the Special Review Board (SRB) for transfer or provisional discharge of these clients to an alternative setting.

MSOP should develop and implement a plan for managing transferred or provisionally discharged low functioning alternative program clients in an alternative setting.

Some low functioning MSOP clients lack the capacity to complete MSOP's cognitively based treatment program. Keeping these clients, some of whom can be managed without being kept in a high security facility, at an MSOP facility is counterproductive. MSOP should treat these individuals to the extent that their cognitive abilities allow and then petition the SRB for transfer or provisional discharge of these clients to an alternative setting that can provide individualized support to these clients.

MSOP has the capacity to evaluate whether certain alternative program clients have received the maximum benefit from sex offender treatment and can manage their risk with continued support. MSOP also has the legal authority to petition the SRB for placement of these clients in either another treatment center or provisionally discharging these clients.[30] These clients can likely be safely managed in a group home or facility that is focused on helping them maintain daily living skills and retaining the sex offender treatment behaviors and concepts they have learned. MSOP should develop and implement a plan so that these clients can reside at a facility or in a group home that is more appropriate to their needs while at the same time protecting public safety.

Clients with Cognitive Deficits in the General MSOP Population

Some clients struggle in the conventional program due to cognitive difficulties.

Clients with severe disabilities are placed in the alternative program. However, according to our file reviews and interviews with clinicians, many clients in the conventional program also struggle with cognitive difficulties. We found that:

- **MSOP has had difficulty identifying and meeting the needs of some clients with low IQs, learning disabilities, memory problems, and certain less obvious cognitive problems.**

Identifying clients with low IQs, learning disabilities, and other cognitive disabilities can be very difficult in any context. Failing to identify and meet the special needs of clients at MSOP facilities can result in a client not participating

[30] *Minnesota Statutes* 2010, 253B.185B, subd. 9(c), provides that the head of the treatment facility may petition the SRB for a reduction in custody. This includes transfer to another treatment facility as well as provisional discharge and discharge.

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in treatment (for example, because they cannot read), not progressing in treatment, or progressing very slowly in treatment. Clients with learning disabilities or other special needs at MSOP facilities have often developed ways to mask their disabilities through more advanced social skills. Masking their disabilities can be a form of survival for clients who do not want to be perceived as vulnerable or "slow" by other clients. In addition, it may be hard to identify some clients with cognitive issues because they refuse to participate in treatment, so there is no opportunity to observe the client struggling.

Suspicions that clients are malingering can also affect whether clients' special needs are identified in a timely way. Treatment is hard for many clients and clinicians sometimes suspect that a client is unwilling to put in the hard work required rather than being unable to do the work.

We saw evidence in client files that some clients' progress was delayed because clinicians suspected they were malingering or not trying when, in fact, they had cognitive or learning disabilities that hindered their treatment. For example, a MSOP psychologist concluded in one file that a client was faking his memory problems and inability to understand treatment. Four years later, a neuropsychological assessment was ordered, and it showed that the client's working memory was poor and affected his ability to learn treatment concepts.

We also found that:

- **MSOP adapts materials and provides supplemental education to clients who need extra help, although clinicians said some clients' needs are still unmet**.

Clients with low IQs, learning disabilities, and other cognitive difficulties who do not meet the criteria for the alternative program are assisted in conventional treatment groups through individual tutoring, treatment assignment modifications, and supplemental education classes. Treatment at MSOP facilities is based on critical thinking, reading, and writing. Failure to address learning disabilities or academic deficits can hold clients back. We found evidence in some clients' files that learning disabilities and academic deficits were identified, and that the program worked with clients individually to help them in their treatment. For example, MSOP facilitators simplified handouts and made audiotapes for one client. Another client was identified as having academic deficits and was given supplemental education.

Clinicians expressed concern that some client needs continue to be unmet. One clinician described how some clients struggling in the conventional program were referred, but not accepted, to the alternative program. There are no firm criteria for clients to be admitted to the alternative program. Rather, clients are assessed on an individual basis to see if the alternative program is appropriate for them. Another clinician stated that Moose Lake had once established a group for individuals with cognitive difficulties, but running the group was too exhausting for already overworked staff. In addition, clinicians felt that ad hoc supports offered to clients have sometimes been insufficient.

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Clients with Psychiatric Needs

MSOP is required by a Department of Human Services (DHS) rule to have a psychiatrist perform evaluations, prescribe medications, and monitor clients needing psychiatric care. In the past, State Operated Services provided all psychiatric care for MSOP clients. Since 2008 when MSOP separated from State Operated Services, MSOP has had to find alternate psychiatric services. We found that:

- **MSOP does not have a staff psychiatrist and has had difficulty contracting with an outside psychiatrist.**

Professionals we interviewed expressed concern that the psychiatric needs of some clients are not fully met, thus making treatment difficult.

MSOP employs psychologists trained in general mental health issues, as well as a physician and psychiatric nurse practitioner. MSOP receives a variance from DHS which allows licensed mental health professionals (such as a licensed psychologist or a psychiatric nurse practitioner) to perform some of the functions of a psychiatrist. These functions include evaluations of clients and prescribing and monitoring the use of psychotropic medication. The variance requires a psychiatrist to review new medications and medication changes. Clients receiving psychotropic medications must be seen in person or via internet conferencing every 12 months. While the program currently has a psychiatrist on contract to see clients via internet conferencing and is currently in compliance with the variance, MSOP has had difficulty in the past retaining a contract psychiatrist. As a result, clinical staff, outside advocates, and clients expressed concern that some clients' psychiatric needs have not been fully met. Failure to address the psychiatric problems of some clients may interfere with the clients' ability to receive sex offender treatment. Further, it can be difficult to discern whether clients with behavioral problems suffer from a mental illness that interferes with their treatment or are purposefully misbehaving.

RECOMMENDATION

MSOP should assure that clients have access to psychiatric care.

CLIENT RELEASES

To date, MSOP has not had any "successes" in releasing clients. In this chapter, we discussed how inconsistency in clinical leadership, clinical vacancies, a problematic treatment environment, vague standards for assessing treatment progress, and the challenges of meetings clients' special needs have likely contributed to the lack of releases. In this section, we discuss how Minnesota's standards for release may also contribute to the lack of client releases from MSOP.

Minnesota statutes spell out the process for reductions in custody that may occur after a sex offender receives treatment at an MSOP facility. A reduction in custody means a provisional discharge or a discharge from commitment. It also includes a transfer out of a secure treatment facility and into another treatment facility, with the only option currently used being MSOP's Community

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Preparation Services, a transitional residence located on the St. Peter campus outside the secured area.

Minnesota law requires the Commissioner of the Department of Human Services (DHS) to establish one or more panels of a special review board (SRB) which consists of three members. One panel member must be an attorney and one must be a psychiatrist. All members must be experienced in the field of mental illness. No member can be affiliated with DHS. Petitions for reductions in custody or an appeal of a revocation of provisional discharge may be filed with SRB by the committed person or the head of MSOP.[31]

The courts make final decisions regarding client releases.

SRB must hold a hearing on each petition and consider any statements from victims. Within 30 days of the hearing, SRB must issue written findings and recommend denial or approval of any petition to a judicial appeal panel. The commissioner must forward the recommendation to the panel. The judicial appeal panel (also known as the Supreme Court Appeal Panel, or SCAP) is a panel established by the Supreme Court. It consists of three judges and four alternate judges appointed from the acting judges in the state. Each member serves for one year. Three judges from the panel hear petitions for a rehearing and reconsideration of SRB recommendations.

Following SRB's decision, the committed person, county attorney from the county of commitment, or commissioner may file a petition for rehearing and reconsideration by SCAP.[32] If no party petitions SCAP, SCAP may either adopt SRB recommendations or set the matter for a hearing. Any person may oppose the petition to SCAP. SCAP decisions may be appealed to the Minnesota Court of Appeals within 60 days of the SCAP decision.

No civilly committed sex offender may be transferred, discharged, or provisionally discharged without majority approval of SCAP. Upon approval by SCAP, the commissioner may transfer a civilly committed sex offender out of the secure treatment center to another treatment center when a transfer is appropriate. In determining whether a transfer is appropriate, the following factors must be considered: (1) the person's clinical progress and present treatment needs, (2) the need for security to accomplish continuing treatment, (3) the need for continued institutionalization, (4) which facility can best meet the person's needs, and (5) whether the transfer can be accomplished with a reasonable degree of safety for the public.

Treatment progress is one of the factors considered by the courts in release decisions.

Factors to be considered in determining whether a committed person may be provisionally discharged include: (1) "whether the patient's course of treatment and present mental status indicate that there is no longer a need for treatment and supervision in the patient's current treatment setting; and (2) whether the

[31] The committed person may not petition the SRB sooner than six months following the issuance of the commitment order and exhaustion of appeal rights. The committed person may petition SRB every six months after an SRB recommendation or after appeals of the SRB recommendation have been exhausted.

[32] The petition must be filed with the Supreme Court within 30 days of when the commissioner forwarded the SRB decision to SCAP. The hearing must be held within 180 days of the filing of the petition.

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conditions of the provisional discharge plan will provide a reasonable degree of protection to the public and will enable the patient to adjust successfully to the community."[33] A provisional discharge plan must be developed, implemented, and monitored by the head of MSOP.[34]

A civilly committed sex offender may be fully discharged only after a determination is made by SRB and SCAP that the person "is capable of making an acceptable adjustment to open society, is no longer dangerous to the public, and is no longer in need of inpatient treatment and supervision." In making a determination regarding discharge, SCAP and SRB must consider whether "specific conditions exist to provide a reasonable degree of protection to the public and to assist the patient in adjusting to the community."[35] If those conditions do not exist, the discharge cannot be granted. A 1995 Minnesota Supreme Court case established that solely proving that a committed person no longer meets the commitment standard was not sufficient to justify discharge of that individual.[36]

MSOP must provide supervision, aftercare, and case management services for civilly committed sex offenders who have been discharged. Prior to discharge, the head of the treatment facility shall establish a continuing plan of aftercare services, including assisting the client in finding employment, shelter, and adequate health care services.

As discussed above, Minnesota law currently allows civilly committed sex offenders to be transferred, provisionally discharged, and discharged if they can be treated in alternative settings in a way that protects public safety. However, as discussed in Chapter 2, there are currently few options for treating and supervising these offenders in the community.

In addition, we found that:

- **Release decisions have been made with a conservative approach to public safety.**

There is generally a high level of public concern about releasing sex offenders into the community. When we asked MSOP clinicians why clients had not been released from the program, they stated that they felt that there is public pressure on SRB and on judges making release decisions to be extraordinarily conservative in releasing clients. They felt that it was difficult for any individual to take the risk to release a sex offender because sex offenders are so reviled in the community and because there is always some risk that the sex offender will reoffend. Clinicians, clients, and outside treatment providers we interviewed also pointed to the Governor's 2003 executive order not to release any sex offenders from commitment without a court order as evidence of the lack of support for

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[33] *Minnesota Statutes* 2010, 253B.185, subd. 12.

[34] The head of MSOP may revoke a provisional discharge if the client violates the conditions of the provisional discharge plan or the client exhibits behavior that may be dangerous to self or others.

[35] *Minnesota Statutes* 2010, 253B.185, subd. 18.

[36] Call v. Gomez, 535 N.W.2d 312 (Minn. 1995).

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releasing these clients. In addition, despite support of the MSOP for provisional discharge of two clients, the Commissioner of Human Services recently petitioned SCAP for reconsideration and rehearing of two SRB recommendations to grant MSOP clients provisional discharge.

MSOP makes treatment progression decisions conservatively and only supports those who have completed treatment for release.

MSOP also takes a very conservative approach to progression and release decisions. Although clinicians told us they felt no pressure from within the program to either hold clients back or advance them in treatment, they stated that they have an obligation to public safety and are therefore very careful in making recommendations. This was consistent with what we saw in our file reviews.

In addition, we found that:

- **MSOP does not support clients for provisional or final discharge unless they have completed the MSOP treatment program.**

It is MSOP policy to not support clients for release, provisional discharge, or transfers to CPS unless they have completed all three phases of the MSOP treatment program. MSOP clients' course of treatment and need for continued treatment at MSOP facilities are two factors considered by SRB and SCAP in making release decisions. SRB relies on MSOP treatment team reports and an MSOP risk assessment in making their recommendations to SCAP. Clients who appeal cases to SCAP have an opportunity to have an outside expert review their treatment status and current risk as well. However, both SRB and SCAP probably rely greatly on MSOP's assessments of their clients.

While MSOP as an institution does not support the provisional or final discharge of clients without first finishing MSOP treatment, many MSOP clinicians we interviewed felt that some MSOP clients could be treated and supervised in the community without first completing treatment in MSOP's secure facilities. We found that:

- **There are clients who, due to age or disability, could likely be managed in alternative settings to MSOP facilities.**

For example, in the previous section, we reported that some low functioning clients in the MSOP alternative program may not ever be able to complete MSOP treatment. However, some of these clients would likely be manageable in group homes because they do not need to be in a highly secure environment (although ongoing security precautions may be needed). There are also clients at MSOP facilities who have become physically and/or mentally handicapped due to strokes, old age, or accidents. While some of these offenders may continue to be high risk and have already sexually offended late into their lives, some of these clients do not necessarily need the type of high security provided at MSOP facilities. These clients would not be released into open society, but could be managed (with extra safeguards) in a nursing home (possibly the forensic nursing home at the Minnesota Security Hospital) or a specialized assisted living facility.

In evaluating release criteria, we compared Minnesota's standard for releasing civilly committed sex offenders to other states' standards for release and found that:

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- **Unlike most other states, Minnesota does not allow offenders to be released from commitment when they no longer meet commitment criteria.**

Minnesota is one of three states that do not release offenders once they no longer meet commitment criteria.

Minnesota is one of three states that do not expressly allow the release of committed sex offenders once they no longer meet commitment criteria. The standards used in Minnesota for reduction of custody decisions are quite different from standards used to make commitment decisions. For example, in order to be committed as a sexually dangerous person, a person must: (1) have engaged in a course of harmful conduct; (2) suffer from a current disorder or dysfunction; and (3) be unable to adequately control his or her behavior, such that the person is highly likely to commit additional harmful sexual acts.

The effect of having different standards for commitment and reduction of custody is that clients are not automatically granted a reduction in custody when they no longer meet commitment criteria. Therefore, a client's progress in the treatment program continues to be a factor in considering a reduction in custody, even if the client no longer has a mental disorder or is no longer highly likely to commit additional acts of sexual harm.

For example, MSOP clients' diagnoses can change. A client who no longer has a disorder that could result in inadequate control of his behavior would no longer meet the commitment standard. We read some files of clients whose crimes were exclusively against other children when they themselves were juveniles. These clients were sometimes originally given diagnoses of pedophilia. Some clients in this situation have had their diagnoses changed because, as adults, they do not have a persistent attraction to children.

Some MSOP clients may no longer meet the standard for commitment.

Some clients may no longer be considered "highly likely" to commit additional acts of sexual harm. For example, some clients were committed prior to development of actuarial risk assessment tools or after scoring norms on actuarial tools were changed. Courts often rely on these tools to help them determine whether or not someone is highly likely to commit additional sexual harm. Prior to the development of actuarial tools, courts had to more heavily rely on experts' clinical judgment, which research has shown to be the least reliable predictor of risk.[37] If assessed with current actuarial tools, some of these clients could no longer be found to be high risk. Scoring norms have also changed on some of these tools. Some clients at MSOP facilities may no longer be considered high risk if scored under new scoring norms based on the newest research.[38]

The Legislature may want to consider changing the standard for releasing civilly committed sex offenders. For example:

[37] For example, see Karl Hanson, *Risk Assessment* (Beaverton, OR: Association for the Treatment of Sexual Abusers, 2000).

[38] In particular, the developers of the Static-99, a widely used tool to assess static risk, recently changed the scoring norms to account for offender age in calculating risk. New research on this tool also indicates that the tool may not accurately predict risk without taking into account the offender's dynamic risk factors.

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- **The Legislature could consider amending provisional discharge criteria to allow for the provisional discharge of offenders who no longer meet commitment criteria.**

This change would make Minnesota's release standard conform more closely to that of most other states. We are specifically suggesting consideration of amending the *provisional* discharge standard. Allowing those offenders who no longer meet commitment criteria to be provisionally (rather than fully) discharged would give MSOP the ability to assure that these offenders receive treatment and are supervised in the community. It would also assure that offenders receive support in finding housing and adjusting back to community life.

It is unclear, however, how many existing MSOP clients would qualify for provisional discharge under a new release standard. Changing the release standard could potentially result in a large number of clients petitioning for, and being granted, provisional discharge. One alternative to changing the provisional discharge standard would be to consider alternatives to commitment at a high security facility as discussed in Chapter 2. If options exist for treating and supervising offenders in alternative settings, SRB and SCAP may find that some currently committed offenders can be safely transferred to these alternative settings rather than remain at the MSOP high security facility.

Whether the Legislature changes the provisional discharge standard or provides alternatives to commitment, there will likely be many clients who will seek to be reassessed to determine whether they can be treated and supervised in settings outside of MSOP's secure facilities. We looked at how other states reassess their civilly committed sex offenders. In most states that reevaluate whether civilly committed offenders have fallen below the commitment threshold, reports are made periodically to the courts to determine whether the offender can be safely released or placed in a less restrictive alternative. If Minnesota changes its release standard or creates alternatives to commitment, the state would need to develop a way to periodically and independently review clients at MSOP facilities to determine whether provisional discharge or an alternative to the secure facility is appropriate.

Requiring an independent body to review client cases would allow MSOP to share responsibility for making release decisions. This would shelter both MSOP and the decision-making entity from unpopular decisions. Further, independent reviews would assure that decisions on provisional discharges or placement in alternatives to the secure facility are based on risk, not treatment performance. A 2006 study of states' release processes found that when a treatment program has a policy of not recommending release until treatment is completed (as is the case in Minnesota) and the program must make decisions regarding provisional releases, provisional releases are unlikely.[39]

The Legislature could require SRB to periodically reevaluate MSOP clients to determine whether they continue to meet the commitment standard or can be

[39] Dennis Doren, *The Model for Considering Release of Civilly Committed Sexual Offenders* in The Sexual Predator: Law and Public Policy; Clinical Practice ed. Anita Schlank (New Jersey: 2006).

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managed in a less restrictive alternative to MSOP facilities. This would require the Legislature to amend state statute to require periodic reviews rather than waiting for clients to petition SRB. In the alternative, the Legislature could use SCAP or another court to review clients at MSOP facilities.

The Legislature could consider establishing an independent periodic review of MSOP clients to determine if they are manageable in alternative settings.

The Legislature should also decide what evidence SRB or the reviewing court receives as part of their review process. Some states rely exclusively on a report from the treatment program to make release decisions. Other states use independent forensic experts as witnesses. In its current reviews of client petitions, SRB relies on a report from the MSOP treatment team and MSOP's risk assessment department. The client does not have a right to a risk assessment and forensic examination from an expert independent of MSOP unless he petitions his case to SCAP. The Legislature may want to consider allowing expert testimony independent of MSOP in reviews of whether clients can be managed in the community or no longer meet commitment criteria.

If the Legislature amends the provisional discharge standard or develops less restrictive alternatives to MSOP secure confinement, then:

- **The Legislature could consider amending state law to require a periodic review of clients by an entity independent of MSOP.**

Currently, there is one occasion where Minnesota law allows the courts to reevaluate whether an offender continues to meet the commitment standard. Sixty days after an initial commitment is ordered, the committing court must review the case to determine whether commitment continues to be necessary. However, this provision in the law was originally designed for mentally ill and dangerous patients whose condition can be quickly stabilized with psychiatric medication. The 60-day review in the context of civil commitment of sex offenders is not useful because the risk these offenders present to the community would rarely change after 60 days. After the 60-day review and final commitment, the committing court can no longer review the client to see if the commitment criteria continues to be met.

RECOMMENDATION

The Legislature should amend Minnesota law to eliminate the 60-day review of initial commitments of sex offenders as required in Minnesota Statutes 253B.18, subd. 2.

As discussed above, we believe that there are more meaningful ways to review whether MSOP clients continue to need to be committed in a highly secure treatment program. The 60-day review does not amount to a meaningful review of the need for commitment.

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List of Recommendations

- The Legislature should require MSOP to develop a plan for alternative facilities for use by certain sex offenders currently at MSOP, as well as for certain newly committed individuals. The plan should provide details about funding and needed statutory changes to ensure adequate supervision, monitoring, and treatment of these sex offenders. The plan should also address the funding and statutory changes needed to address a stay of commitment option. The cost impact of these options should be compared with the costs of expected growth at MSOP without any change in policy. The plan should be presented to the 2012 Legislature. (p. 45)

- MSOP should reassess its existing residents to determine which residents would be suitable for placement in an alternative setting. The plan presented to the 2012 Legislature should provide information on this reassessment, including the rationale for determining why certain types of residents would be suitable for an alternative commitment setting and a detailed description of the alternative settings being proposed for various groups. (p. 46)

- The Legislature should consider providing for indeterminate sentencing for some sex offenders. As a condition of their release, offenders could be required to successfully complete treatment in prison. (p. 46)

- The Legislature should direct the Department of Human Services to convene a task force to consider the need for changes in the sex offender commitment standard and process, including the advisability of establishing a centralized prosecution structure and a single commitment court for sex offenders. The Legislature could also direct the department to have the task force examine the referral process. The task force should be required to report its findings and recommendations to the 2012 Legislature. (p. 48)

- The Legislature should direct the Department of Human Services to work with stakeholders and the Office of the Revisor of Statutes to develop a proposal for separating the civil commitment statutes for sex offenders from those governing the civil commitment of other populations. (p. 49)

- The Legislature should direct the Department of Corrections to study the recidivism rates of sex offenders who have been referred or petitioned for civil commitment and not civilly committed and report back to the 2012 Legislature. The department should also analyze whether there are geographical differences in the recidivism rates for these populations. These recidivism rates could also be compared to the rates experienced by other sex offenders who have been released from prison but not referred for civil commitment. (p. 49)

- The Department of Human Services should require MSOP to provide more treatment hours per week. (p. 65)

- In evaluating designs for the construction of new living units for MSOP, the Legislature and DHS should consider the tradeoffs between the efficiency of

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staffing large units and the effect of larger units on the therapeutic environment. (p. 67)

- As clinician positions become fully staffed and clinician offices are located in living units, MSOP should closely monitor whether staffing in living units is sufficient to improve the therapeutic environment. (p. 70)

- MSOP should consider creating an incremental privilege system for clients in the early phases of treatment in order to increase client motivation. (p. 72)

- MSOP should train and supervise clinical staff to assure that quarterly and annual reviews contain enough specific detail to provide meaningful feedback to clients and others regarding treatment progress. (p. 74)

- MSOP should complete the treatment manual. This manual should include clear clinical guidance on the interpretation of the matrix. (p. 77)

- MSOP should develop and implement a plan for identifying when certain low functioning alternative program clients who are not cognitively able to complete treatment can be managed in a less restrictive setting. MSOP should petition the Special Review Board (SRB) for transfer or provisional discharge of these clients to an alternative setting. (p. 83)

- MSOP should develop and implement a plan for managing transferred or provisionally discharged low functioning alternative program clients in an alternative setting. (p. 83)

- MSOP should assure that clients have access to psychiatric care. (p. 85)

- The Legislature should amend Minnesota law to eliminate the 60-day review of initial commitments of sex offenders as required in *Minnesota Statutes* 253B.18, subd. 2. (p. 91)

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Minnesota Department of **Human Services**

March 3, 2011

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to your program evaluation report "Civil Commitment of Sex Offenders." The Department of Human Services (DHS) appreciates the time and effort of the Office of the Legislative Auditor in reviewing the civil commitment process for sex offenders. This report confirms the complexity of the sex offender civil commitment process and validates the significant work of the Minnesota Sex Offender Program (MSOP).

Your team did a thorough review and analysis of the civil comment process for sex offenders. We believe this report reflects that hard work and objectivity. It is our hope that this report serves as a practical tool for policy makers in analyzing our current statutes and processes around the civil commitment of individuals with histories of sexual offenses.

The Department supports the majority of the recommendations made in the report. Many of the findings and recommendations are consistent with current objectives and goals to continue to provide sex offender treatment in a safe and secure facility. As you are aware, MSOP is in the process of implementing many enhancements to the program and has several pending policy changes which are consistent with the report's recommendations. The Department provided the Legislature with a report late last year with recommendations which are in accord with those of the report.

The following are a few recommendations that DHS would like to specifically address:

- The report outlines several recommendations to the Legislature requiring DHS to take the lead in coordinating major policy discussions around sex offender civil commitment. The Department is committed to working with the Legislature to provide leadership, expertise, and information on sex offender civil commitment to help implement these recommendations. We support getting the key stakeholders together and jointly discussing changes that will improve the overall civil commitment process.

- We agree with the recommendation that MSOP should be increase treatment hours and are taking active steps to reach that goal.

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- MSOP is responsible for providing health care services to all clients. External licensing authorities provide requirements for MSOP regarding client access to medical care including all psychiatric services. MSOP continues to streamline and develop internal processes for these services, which were previously provided by State Operated Services (DHS). MSOP currently has contracts, and will continue to contract, with community-based psychiatric providers who are experienced in treating sexual offenders.

- MSOP is committed to balancing the demands of treating civilly committed sex offenders in a secure setting. Creating a therapeutic environment in a secure setting while maintaining fiscal responsibility can be challenging. MSOP will continue to consider the tradeoff between efficiency of staffing large units and the effect of larger units on the therapeutic environment when presenting the Legislature with options of expansion.

- As in all civil commitment programs, MSOP recognizes the importance of identifying and articulating client progress in treatment (i.e. dynamic risk factors). MSOP is committed to improving the professional competency of clinical staff through trainings and regularly scheduled clinical supervision. MSOP will have a completed program manual to accompany the theory manual, by the end of the calendar year, providing a further foundation for clinicians regarding treatment design and program philosophy.

- MSOP recognizes the unique treatment needs of lower-functioning sex offenders and is committed to assisting these clients in decreasing their risk to the best of their abilities. Treatment progress is reviewed quarterly and individual plans are adjusted accordingly. MSOP is currently seeking alternative settings for the lower-functioning clients, in preparation for when a court approves a transfer or a provisional discharge.

Thank you again for the hard work of your office conducting this evaluation and addressing important issues regarding civilly committed sex offenders.

Sincerely,

Lucinda E. Jesson
Commissioner

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MINNESOTA DEPARTMENT OF CORRECTIONS

OFFICE OF THE COMMISSIONER

Contributing to a Safer Minnesota

March 2, 2011

James R. Nobles, Legislative Auditor
Office of the legislative Auditor
140 Centennial Office Building
658 Cedar Street
St. Paul Minnesota 55155-4708

Dear Mr. Nobles:

Thank you for the opportunity to review and comment on your report on Civil Commitment of Sex Offenders. As noted in your report the Department of Corrections screens the sex offender population prior to release from incarceration and forwards to county attorneys those cases that may be appropriate for a civil commitment petition. As noted in your report the Department's referral policy and practice is consistent with state law, is empirically based, and is not influenced by the racial or geographical background of offenders.

The Department recognizes the concerns regarding the sustainability of the current size and rate of growth of the Minnesota Sex Offender Program. We recognize the important role our referral process plays in the commitment process. We are prepared to readily implement any changes in our procedures as legislatively directed.

Sincerely,

Tom Roy
Commissioner

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