MINNESOTA DIRECT CARE AND TREATMENT ADVISORY COMMITTEE MEETING MINUTES

Meeting Information

- **Date and Time:** Friday, March 13, 2025, from 1:00-3:00 pm CT
- **Location:** In-person location at Minnesota State Capitol, 75 Dr. Rev. Martin Luther King, Jr. Blvd, St. Paul, MN. 55155, Room G23, and a virtual meeting available via Zoom
- **Direct Care and Treatment (DCT) Advisory Committee Attendees:** Chair Dave Baker; Vice Chair Bianca Virnig; Senator John Hoffman; Senator Paul Utke; Commissioner Tara Jebens-Singh; Marcus Schmit; Jessica Langhorst; James Carlson; and Jim Postier
- **DCT Advisory Committee Facilitators:** Jill Kemper and Danielle Swanson, Health Management Associates (HMA)
- **Speakers:** Dale Klitzke, Chief General Counsel, DCT; Nancy Johnston MSSW, Executive Director; Calynn Schuck, Deputy General Counsel, DCT General Counsel's Office; Marshall Smith, Chief Executive Officer (CEO), DCT; Dan Storkamp, External Relations Executive Director, DCT

Meeting Summary

- **Welcome**
    - Vice Chair Bianca Virnig welcomed members to the third MN DCT Advisory Committee meeting before turning the time over to the speakers to present on the Minnesota Sex Offender Program (MSOP).
- **Presentation: MSOP**
    - Dale Klitzke, Chief General Counsel, DCT, began by thanking the group for allowing them to present today on the MSOP and reminded attendees that the presentation was intended to educate the members of the Advisory Committee and the public by explaining the program's purpose, while at the same time protecting privacy and upholding individuals' rights.
    - Nancy Johnston MSSW, Executive Director and Calynn Schuck, Deputy General Counsel, DCT General Counsel's Office provided an extensive overview of MSOP, including details on the program purpose, history, structure, legal framework, treatment model, and civil commitment process. (*Note: information found on slides is not repeated in the minutes below - see slides 3-48 below for those details*.)

- Johnston emphasized that MSOP does fall under the umbrella of DCT, but like many civil commitment programs nationally, it does not fit neatly within traditional services or state programs. MSOP does not follow a medical model. It provides treatment for clients who are civilly committed to the program to provide safety for both the public and individuals within the facility. MSOP has no authority over admissions or releases (including the number of individuals who are released back into the community). Counties determine who is petitioned for commitment, and courts decide reductions in custody. MSOP's role begins only after a court commitment order is issued.
- Johnston noted that the number of individuals institutionalized through the MSOP rose significantly after the high-profile murder and sexual assault of Dru Sjodin in 2003. In 2008, additional policy changes were implemented at the state and programmatic level. From 2003–2013, the population expanded dramatically, requiring emergency expansion of facilities and restructuring of policies and treatment design. Growth has stabilized over the past decade (to about 20 per year); Minnesota continues to have the largest population of civilly committed individuals as compared to other civil commitment programs in the U.S.
- Johnston reviewed the breadth of accountability MSOP operates under. MSOP is subject to extensive oversight, including court orders, the Hospital Review Board, internal audits, DHS licensing (Rule 26), and external complaint processes.
- After reviewing the phases of treatment, Johnston also clarified that treatment participation is voluntary. Approximately 100 clients at any given time choose not to engage in treatment. These individuals are not segregated into separate units; instead, they are intentionally integrated among clients participating in treatment so that peers who are progressing can encourage accountability and engagement. MSOP cannot force internal motivation or behavioral change.
- Additional details were provided on institutionalization, noting that many clients have been involved in correctional or secure settings since adolescence. Treatment engagement and reintegration readiness significantly impact individuals in long-term institutionalization and are a major reason the program relies heavily on gradual step-down approaches. Johnston noted that once released, clients are no longer supervised, and many choose to leave the state. Additional details are also provided to the community when reintegration is occurring.
- Schuck emphasized that, legally, MSOP is a courts-in/courts-out process, with individuals most often committed to the MSOP via the Department of Corrections. After reviewing the petition and commitment process, Schuck noted that while the court is not required to commit individuals if a less

restrictive facility is available, this is not the reality in Minnesota, meaning that individuals will end up in the MSOP.

- Schuck emphasized that MSOP intentionally separates itself from decision-making and petition authority in the two-step reduction-in-custody process to preserve the integrity of the program, meaning that while the statute allows the Executive Director to submit petitions, MSOP does not do so; all petitions originate from clients and their attorneys. MSOP does, however, provide reports and assessments to the Special Review Board (SRB) for their review.
    - Although statutorily required, the SRB does not have authority to grant or deny reductions in custody. Its role is limited to issuing recommendations, which are then reviewed de novo by the Commitment Appeal Panel (CAP). Schuck acknowledged that this can be a lengthy process, on average taking between 3-4 years for the whole appeals process to conclude.
- The discussion also clarified the burden-shifting framework used in CAP proceedings. In Part One hearings, clients must present only minimal evidence to justify further review. Once that threshold is met, the burden shifts to the Executive Board in Part Two to demonstrate that a reduction in custody is not appropriate, relying heavily on treatment progress reports and risk assessments.

- Discussion following the overview included:
    - James Carlson raised concerns about gaps between prosecution, treatment, and prevention, particularly where individuals with substance use disorders (SUD) and alleged or convicted sexual offenses are housed together in treatment and recovery facilities. He emphasized community discomfort and safety concerns, especially when non-offenders and families are placed in shared spaces without transparency. Carlson questioned eligibility criteria for treatment programs, inconsistencies in sentencing outcomes, and the lack of clear separation between offender and non-offender populations. He stressed the importance of prevention, including anonymous access to resources before harm occurs, and highlighted how technology has increased risks to youth. He also emphasized that community members should be involved beyond attending meetings, and that they can work with agencies or legislators to close systemic gaps while balancing safety, accountability, and access to treatment.
    - Chair Dave Baker asked how Minnesota's civil commitment program compares to other states, particularly why Minnesota's program is so large and what states without civil commitment do instead to manage similar crimes long term. He questioned whether Minnesota's lengthy and costly process, particularly seemingly duplicative steps like the SRB and CAP, produces better public safety outcomes than states that rely on release with supervision or other conditions.

As a legislator, he noted that he wanted to understand whether Minnesota's investment results in measurably better community safety and recidivism outcomes compared to alternative approaches used elsewhere. Marcus Schmit also inquired about the ability to reduce duplication or streamline processes related to SRB and CAP.

- The presenters explained that states differ considerably based on their statutes: states without civil commitment release individuals at the end of their prison terms, sometimes with supervision or mandated treatment, while states with civil commitment commit individuals who meet statutory criteria. Minnesota's unusually large program stems from unanticipated growth following a 2003 tragedy, rather than statutory changes. Comparisons across states are difficult because commitment, review, and release processes vary significantly. Regarding outcomes and process efficiency, the response noted that research shows treatment and supervision significantly reduce risk and recidivism. They acknowledged concerns about the SRB, agreeing it may be duplicative and contribute to delays, and expressed openness to streamlining the process while maintaining safety but that there are statutory requirements which limit their ability to change processes (*see slide 47*).
- Finally, Commissioner Tara Jebens-Singh asked for additional clarification as to whether there are statistics that can be shared on how Minnesota is doing compared to other states. Jebens-Singh also asked what Minnesota is doing to build capacity for a less restrictive environment which can be utilized, as opposed to institutionalization (referenced as a limitation above).
    - Presenters explained that annual national survey data is available comparing states on civil commitment practices, programming, supervision, and release, and that outcome data such as recidivism exists but is difficult to compare across states due to major differences in treatment exposure, supervision, and statutory approaches. They emphasized that civilly committed individuals represent a uniquely high-risk population, making comparisons with non-committed populations complex, though some research comparing these groups does exist.
    - Responding to the second question, presenters noted that this there are significant gaps due to declining funding for outpatient and community-based treatment programs, which limits alternatives to civil commitment and contributes to program

closures. However, Minnesota has been relatively successful in securing community placements for released individuals through sustained relationship-building with local partners, law enforcement, and communities, avoiding some of the housing barriers faced by other states.

- **DCT Executive Board Updates and Strategic Planning Overview**
    - Marshall Smith, CEO, DCT, provided an overview of DCT Executive Board governance, operations, and strategic planning activities. He explained that the public board meets monthly (every third Thursday), outlined board leadership and membership roles, and noted that agendas and minutes are publicly available in advance on the website. Board members are actively engaged through finance, quality, and compliance workgroups, regular reporting, participation in quality and management meetings, and attendance at relevant conferences and strategic planning sessions. Smith also outlined DCT's ongoing strategic planning process to develop the next three-year plan, emphasizing a data-driven, inclusive approach that incorporates leadership direction, staff input, and engagement from both the board and advisory group, with upcoming review of a SWOT (strengths, weaknesses, opportunities, threats) analysis and eventual board approval of the final plan. He noted that Advisory Committee members are invited to join the strategic planning process.
- **DCT Advisory Committee Business**
    - Vice Chair Virnig opened the meeting for discussion on upcoming meeting dates and topics. The Committee agreed to meet on April 24, 2026, and to skip May due to legislative schedules. The Committee also agreed to hold meetings at various DCT facility sites over the next several months. Tentative schedules were discussed as follows:
        - Meetings to take place on the last Friday of each month. Advisory Committee meetings will take place at DCT facility sites in June (Moose Lake), July (St. Peter), and August (Anoka). Additional details will be planned and shared as information becomes available. Meetings will include non-public tours followed by open meetings.
- **Open Public Comment**
    - Vice Chair Virnig introduced the public comment segment of the agenda and welcomed the commenter to share their comments. The comment summary is provided below.
        - Steve Sandell, a former legislator in Minnesota, began by thanking various members of the Advisory Committee and MSOP for their work on these initiatives. Sandell emphasized his concern for both survivors of sexual violence and the state's responsibility to provide effective, ethical treatment for individuals who have committed sexual offenses. He framed his remarks around the goals of preventing sexual assault, aggression, and violence, while questioning whether Minnesota's current approach meaningfully advances

those goals. He explained that his engagement with MSOP began in 2021 while serving on the House Human Services Committee, after receiving a letter from a client at Moose Lake describing conditions and systemic issues that the author believed legislators and administrators had ignored. Building on the committee's earlier discussion of MSOP's administrative structure, Sandell highlighted policy concerns about outcomes and priorities. He stated that Minnesota has devoted the majority of its attention and more than a billion dollars to the civil commitment and long-term confinement of individuals who have already completed their court-imposed prison sentences, even though they are statutorily defined as "patients." While acknowledging that some individuals require extended residential treatment, he stated that the program has been largely unsuccessful in transitioning most clients back into the community. He noted that only a small number of individuals—approximately 34—have been released into the community over several decades, while more than 750 people remain in indeterminate confinement, making Minnesota a national outlier. He reiterated that Minnesota is one of only about 20 states with a civil commitment program like MSOP, yet it is the largest and most expensive on a per-capita basis. He asserted that despite this scale and cost, Minnesota has not demonstrated better outcomes in prevention, rehabilitation, or public safety compared to states without civil commitment programs. He referenced criticism of MSOP from national media outlets, academic literature, and official reviews, which he stated have been largely disregarded by the state. Sandell encouraged the Committee to review the extensive history and research available, to ensure transparency by recording meetings, and to actively engage with past findings rather than revisiting issues already well documented. He asked DCT and its leadership to conduct a candid and comprehensive review of MSOP policies and practices, with greater emphasis on prevention, less restrictive treatment options, meaningful pathways to release, and support for victims and families. He concluded by saying that sexual violence is not solely a women's issue, but a broader issue affecting families, men, children, public health, public safety, and legislative accountability. He called on the Committee to remind lawmakers and state administrators of their responsibility to listen to clients, administrators, and statutorily created advisory councils, and to continue rigorous oversight and discussion.
        - Vice Chair Virnig thanked the commenter and transitioned to the meeting close.
- **Wrap Up and Next Steps**
    - Vice Chair Virnig closed the meeting by noting that more information on the Advisory Committee and upcoming meetings is available on the DCT Advisory Committee webpage. The next meeting will take place on April 24, 2026, from 9:00-11:00 am.

Minnesota Direct Care and Treatment:
Advisory Committee Meeting

MARCH 13, 2026

MINNESOTA STATE CAPITOL

75 DR. REV. MARTIN LUTHER KING JR, BLVD, ROOM G23 & VIA ZOOM

ST. PAUL, MN 55155

Today's Agenda

1. Welcome
2. Presentation: Minnesota Sex Offender Program (MSOP)
3. DCT Executive Board Updates and Strategic Planning Overview
4. DCT Advisory Committee Business
5. Open Public Comment
6. Wrap Up and Next Steps

Presentation: Minnesota Sex Offender Program (MSOP)

Nancy Johnston MSSW, Executive Director

Direct Care and Treatment: Established in 2013

- **Forensics Mental Health Program** (FMHP) includes the "Security Hospital," Forensic Nursing Home, and Transitional Services all on the St. Peter campus.
- **Mental Health and Substance Abuse Treatment Services** (MHSATS) includes Anoka Regional Treatment Center, CARE sites, CBHH sites, and group homes.
- **Community Based Services** (CBS) includes over 100 group homes, respite homes, vocational settings, and foster homes.
- **Minnesota Sex Offender Program** (MSOP) includes secure facilities in Moose Lake and St. Peter and a less restrictive facility outside the perimeter in St. Peter.
- **DCT Out-patient Services** includes dentistry, pharmacy, and outpatient treatment across MN.

Civil Commitment Laws in MN

- Mentally Ill and Dangerous (MI and D) Forensic Mental Health Program (indeterminate commitment)
- Chemically Dependent (CD) Mental Health and Substance Abuse Treatment Services
- Mentally Ill (MI) Mental Health and Substance Abuse Treatment Services
- Developmentally Disabled (DD) Community Based Services
- **Sexually Dangerous Person (SDP) and/or Sexual Psychopathic Personality (SPP)** Minnesota Sex Offender Program (indeterminate commitment)

Where does MSOP fit?

MSOP Vision and Purpose

Vision:

Working to end sexual violence

Purpose:

To promote public safety by providing comprehensive treatment and reintegration opportunities for individuals who are civilly committed for sexually abusive behaviors.

MSOP Program Values

- **Program Integrity** - Services are delivered as intended; common goals maintain consistency and quality across depts and sites; compliance and accountability; protects public funds
- **Therapeutic Environment** - Physical, social, and psychological spaces that support change for individuals and communities; client is center; unified approach; understanding theory and balancing treatment, safety, security; individualized, flexible, and designed to support differing functional levels and approaches
- **Responsibility to the Public** - Maintain safety within facilities and to public; consistent transparency; fulfill obligations to stakeholders; timely responses to concerns and questions; fiscally responsible
- **Learning Organization** - Promotes strong learning environment and valuable learning opportunities; creates, transfers, and modifies philosophy to reflect new knowledge and insights
- **Employee Engagement** - All staff are essential to maintain safe and therapeutic treatment environment; opportunities for staff to contribute meaningfully, be supportive of one another, recognize and acknowledge commitment, and encourage new ideas/alternative ways of thinking

ONE program – TWO campuses – THREE sites

Stats

- About 19,000 registered sexual offenders statewide
- About 14,000 live in our communities
- About 4,000 incarcerated at any given time
- About 1,100 released from confinement each year
- About 20 – 30 clients each year are committed by their county out of 1,100
- About 20 clients are released by the courts to the community each year
- MSOP total client census today is approximately 770, inside our facilities

Unique Clinical Population

Common characteristics of MSOP clients include:

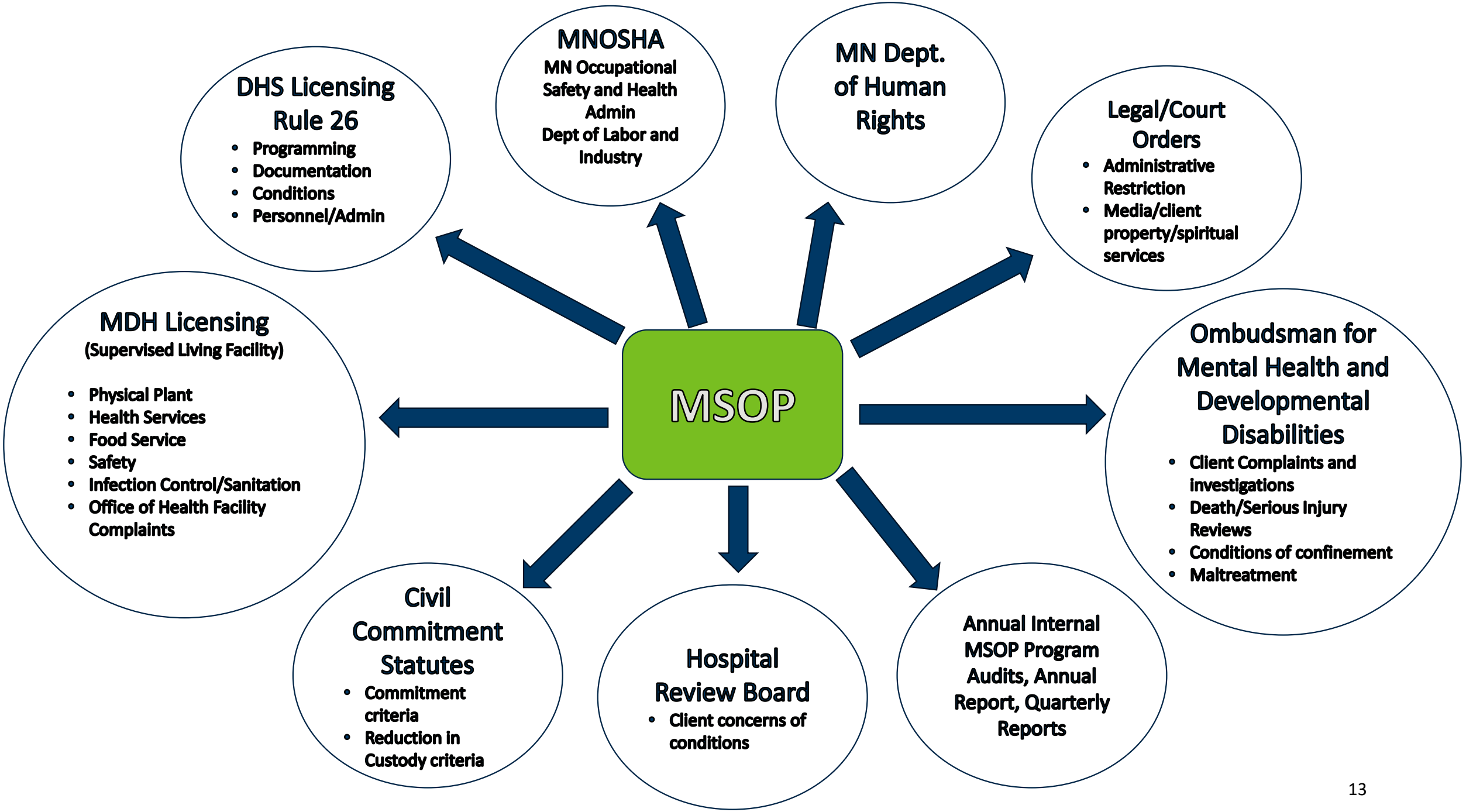
- Higher risk for re-offense
- Patterned sexual deviance/atypical sexual interests
- Anti-social/psychopathic traits
- Generally, not vulnerable adults

Fast Facts

- ***Courts in, courts out process***
- Most clients have served prison sentences for their sex crime
- MSOP provides sex offense specific comprehensive treatment
- **Departments and Disciplines include**:

Clinical, Assessment, Operations, Security, Clinical Programming or "Rehabilitative," Health Services, Policy and Compliance, Safety, Risk Evaluation, Maintenance, Reintegration, Legal, Court Services

- Licensed by DHS and MDH
- MSOP's annual budget is 124m, appropriated for 910 FTEs, currently at approximately 800
- **20** state civil commitment programs exists in the country
- MSOP is the *largest* civil commitment program in the country


MSOP
DHS Licensing Rule 26
Programming
Documentation
Conditions
Personnel/Admin
MNOSHA
MN Occupational Safety and Health Admin
Dept of Labor and Industry
MN Dept. of Human Rights
Legal/Court Orders
Administrative Restriction
Media/client property/spiritual services
MDH Licensing
(Supervised Living Facility)
Physical Plant
Health Services
Food Service
Safety
Infection Control/Sanitation
Office of Health Facility Complaints
Ombudsman for Mental Health and Developmental Disabilities
Client Complaints and investigations
Death/Serious Injury Reviews
Conditions of confinement
Maltreatment
Civil Commitment Statutes
Commitment criteria
Reduction in Custody criteria
Hospital Review Board
Client concerns of conditions
Annual Internal MSOP Program Audits, Annual Report, Quarterly Reports

Services Provided

Sex offense specific treatment (3 phases) – core (process) groups, individual therapy, psycho-educational modules, therapeutic community meetings

Clinical programming ("rehabilitative") – therapeutic recreation, vocational, education, spiritual, and volunteer services

Health services – Nursing, primary care, psychiatry, physical therapy, optometry, dental

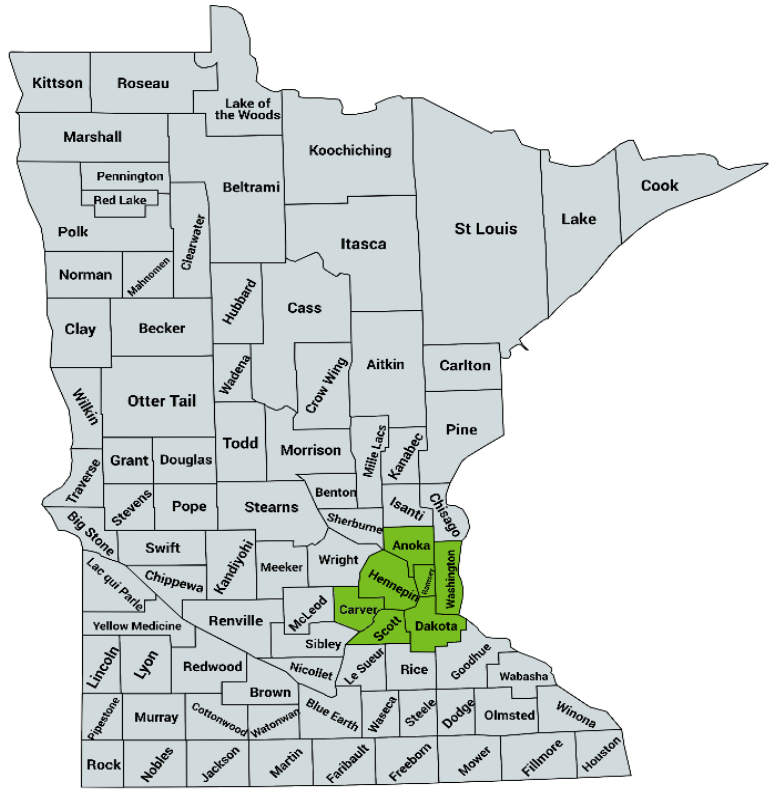
MSOP Census Averages

- Client count within facilities is about **770:**
  - Moose Lake – Approximately **435**
  - St. Peter – Secure Perimeter – Approximately **200**
  - St. Peter – Community Preparation Services – **135**
- DOC – Approximately **15-20**
- Forensic Nursing Home – Approximately **10-12**
- Provisional Discharge – **68**
- **TOTAL – 863**
- ***1012 civilly committed clients in history of MSOP***
- Client average age is **54**, youngest is **21** and the oldest is **92**
- Average age at commitment is **38**

Commitments by County

Civil Commitment by County: Total **833**

- Metro*: **331**
  - Hennepin: **150**
  - Ramsey: **86**
  - Others: **95**
- Non-Metro: **502**



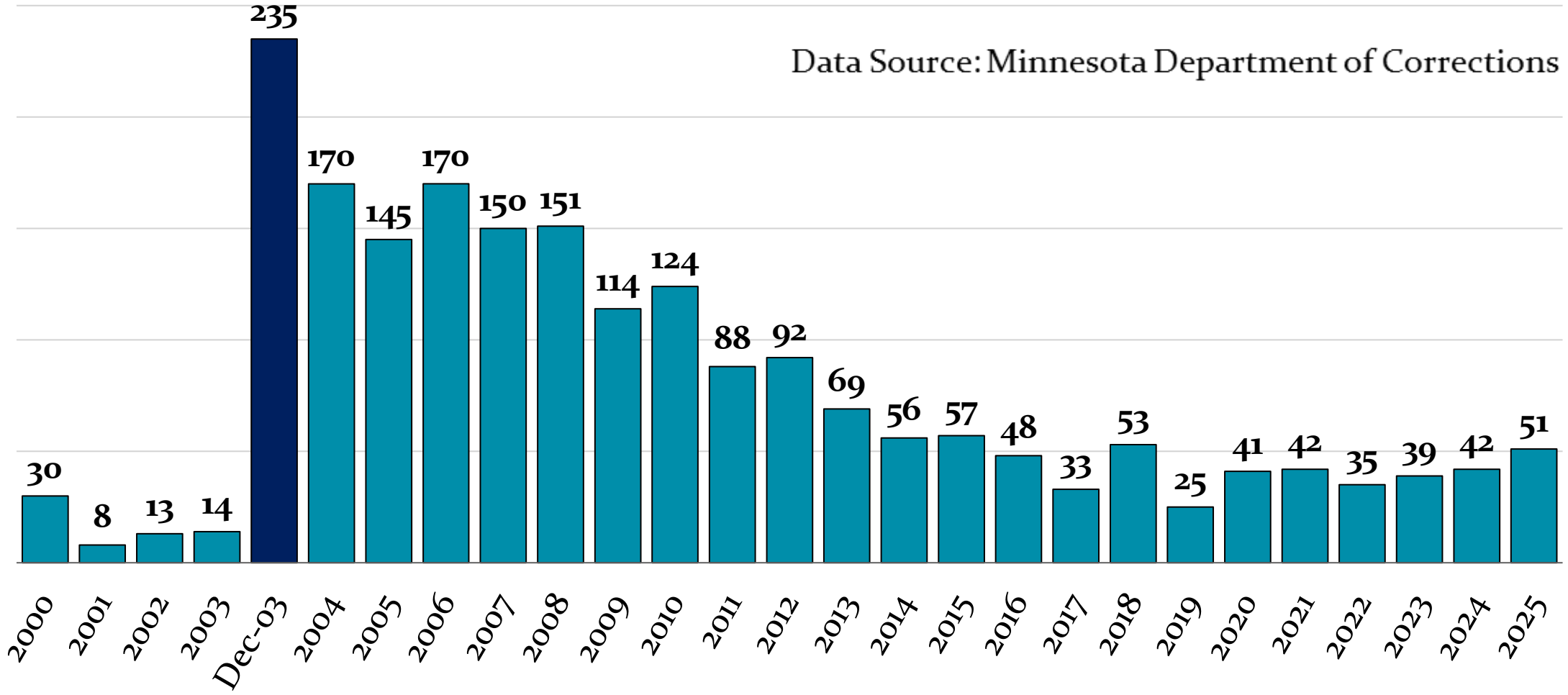
*Metro counties include: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott & Washington. Data as of 2/02/2026.

MN Statutes

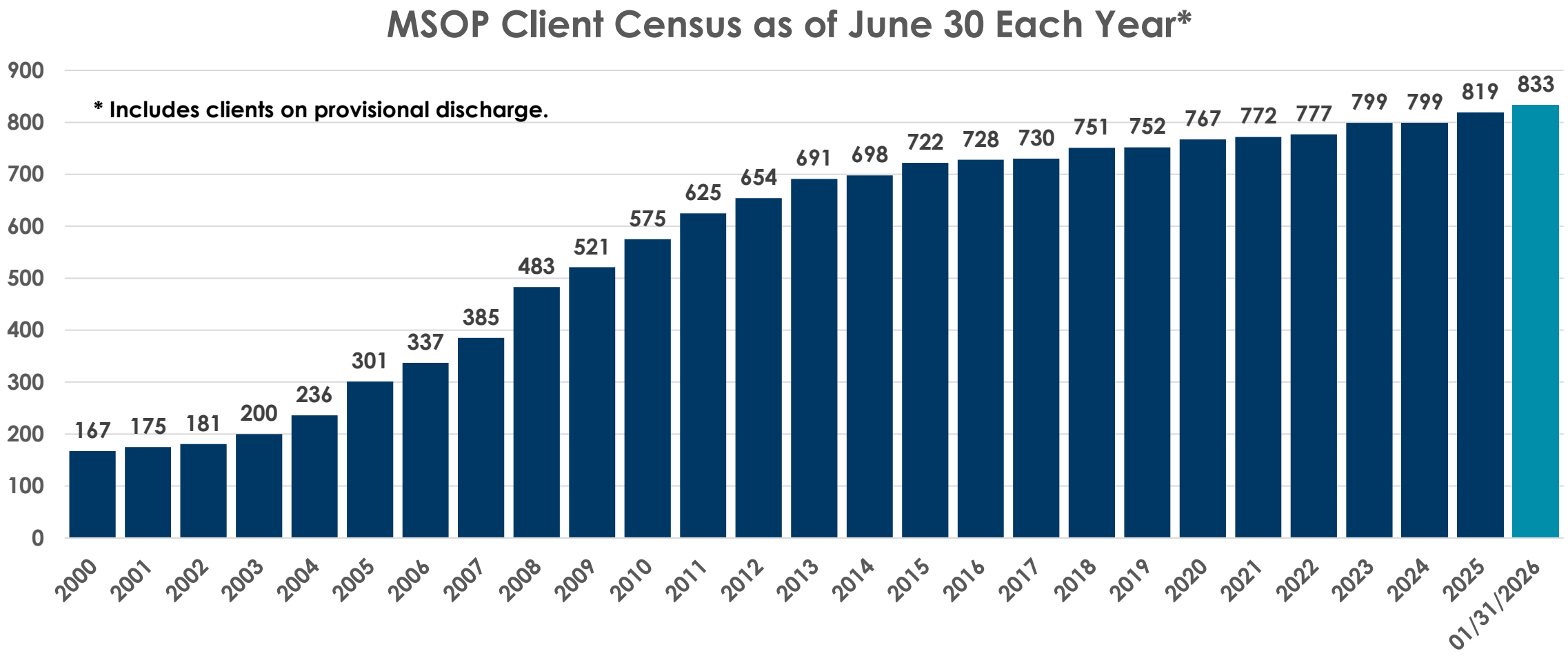
- Civil commitment law enacted in 1939 (Psychopathic Personality), rarely used.
- Civil commitment law “split” 1994, statute was changed from PP to SDP and SPP.
- Used more regularly, about 26 referred and 12 admitted each year after 1994.
- Approximately 200 clients by 2003.

High profile case = population explosion in 2004

SDP/SPP Referrals from DOC to Counties

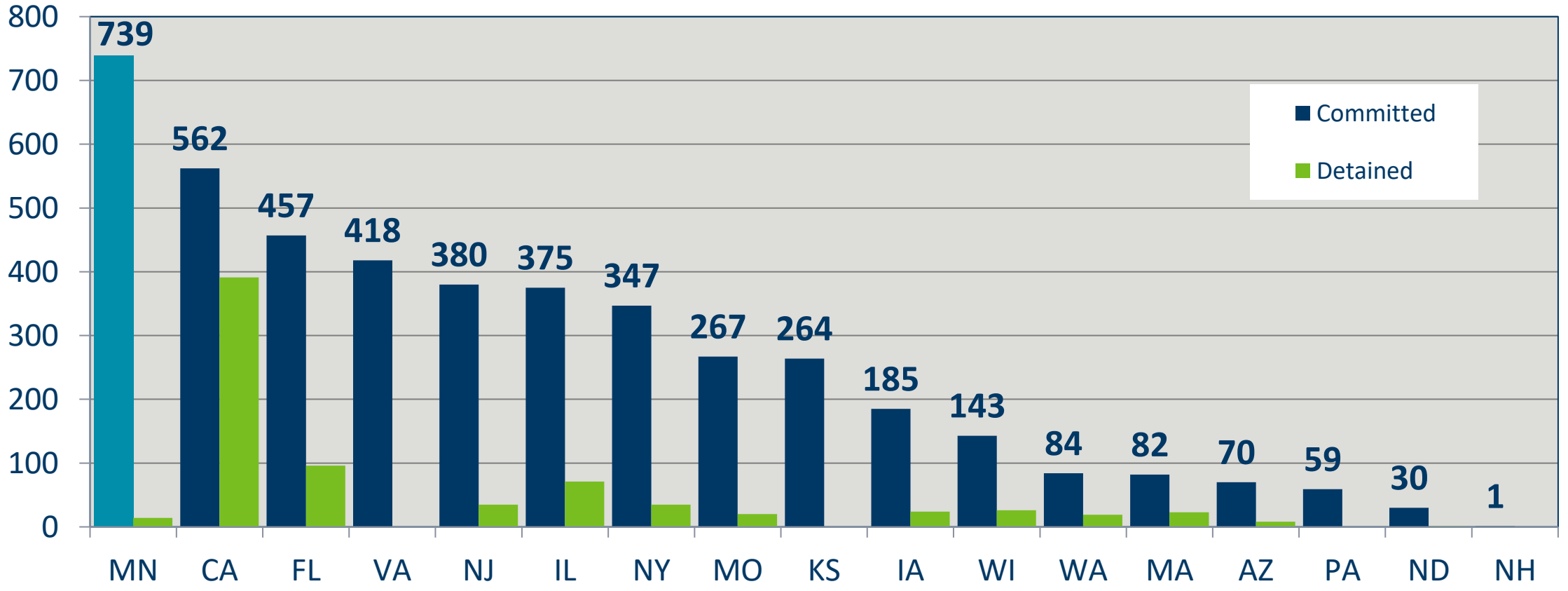


MSOP Client Census



Civil Commitment Census by State

Data from 2025 SOCCPN Annual Survey



Administration Change

2008 Administration Change

1) MSOP **separated** from DCT (then known as State Operated Services) and stood alone under DHS Commissioner (2008 – 2013)

2) BED SPACE, Building, Renovating

3) Safety and ***security*** highest priority within program

4) State of the art sex offense specific **treatment design** created

5) Solid **policy reform** developed and implemented

MSOP Moose Lake

Census typically about 435

Main Site – 150

Six 25-bed units (3 in use)

- Supportive Living units – for clients with acute psychiatric or medical needs
- Omega units – small areas designated for clients with behavioral problems

Moose Lake Complex One – 400

- Two 98 bed wings, Three 68- bed wings
- Conventional programming (Phases I and II), non-participants

MSOP St. Peter

Census typically about 335 inside perimeter and CPS

PEXTON (Four 28 bed units) – 112 beds

- *Alternative Program, 3 units*
- Phases I, II, and III
- *Conventional Program and clients on Hold Status, 1 unit*

SHANTZ (Four 36 bed units) – 144 beds

- *Conventional Program*
- Phases II and III

GREEN ACRES, SUNRISE, and Bartlett Hall – 139 beds

- *Community Preparation Services (CPS)*

Community Preparation Services (CPS)

- An unlocked, less restrictive alternative setting on the lower campus of St. Peter.
- Important “step-down” part of program for deinstitutionalization.
- Clients wear ankle monitors (GPS) and acquire campus and community outings.
- By court order for Transfer, clients move from the secure perimeter to CPS, over 260 transfer orders since inception.
- Established in 2008 with 8 beds, now at 139.
- Currently constructing 30 additional beds within Sunrise, Fall 2026 completion.

Provisional Discharge (PD) & Reintegration

- **Clients granted Provisional Discharge (PD) – 135**
- **PD clients currently in community – 68**
  - Supervised apartment settings, halfway houses, assisted living, group homes, independent housing

Data as of 2/02/2026

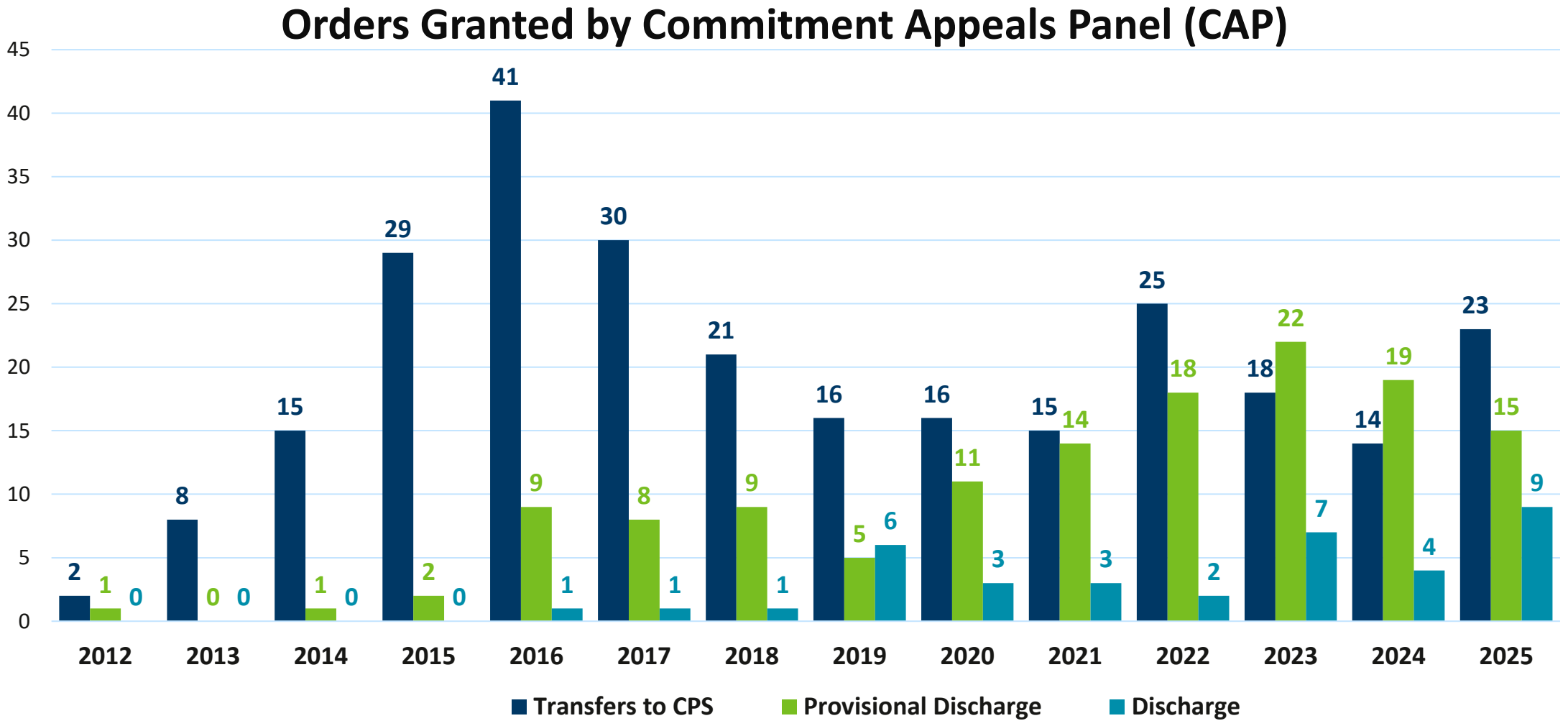
Reintegration Supervision

- ✓ Both an agent and case manager
- ✓ Manage and supervise caseload of 8-10
- ✓ Oversee client's compliance of court-ordered provisional discharge conditions
- ✓ Monitor active and passive GPS
- ✓ Conduct random searches, unannounced visits, and surveillance
- ✓ Conduct urinalysis screening for drugs and alcohol
- ✓ Robust Policy System, Tier System, and outing approval process
- ✓ Collaborate with community support networks/outpatient treatment

Discharge

- **Full Discharge – 37**

MSOP Reduction in Custody, 2012-2025



SCAP/CAP Orders Granted for Reduction in Custody

SCAP/CAP Orders granted in MSOP History (as of 2/04/2026):

- Transfers to CPS: **285**
- Provisional Discharge: **138**
- Full Discharge: **37**
- Total Number Granted: **460**

Treatment


MSOP
working to end sexual violence
MINNESOTA SEX OFFENDER PROGRAM
Phase I
Treatment Goal Matrix
MSOP
working to end sexual violence
MINNESOTA SEX OFFENDER PROGRAM
Phase II
Treatment Goal Matrix
MSOP
working to end sexual violence
MINNESOTA SEX OFFENDER PROGRAM
Phase III
Treatment Goal Matrix

Treatment for Individuals Who Have Sexually Abused

- Continuum of behaviors. Range of pathology and risk
- Range of management tools and treatment interventions-based on individual risk, needs, progress and strengths
- Identified professional field of study based in research with emerging theories and best practices
  - Association for the Prevention and Treatment of Sexual Abuse (**ATSA**)
  - Minnesota chapter- **MnATSA**
  - Sex Offender Civil Commitment Network (**SOCCPN**)

TREATMENT = CHANGE

Manage and control own behavior

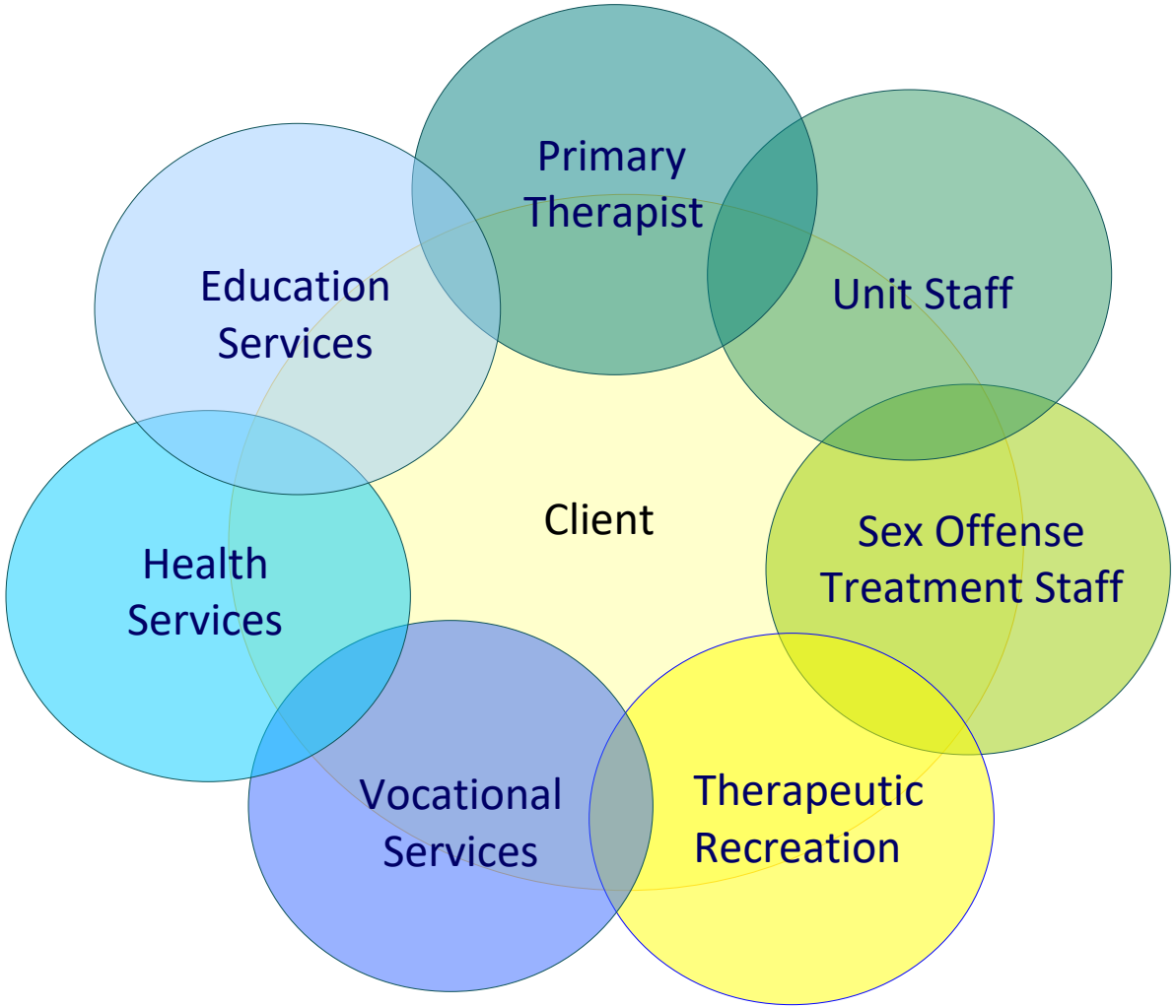
MSOP Principles

Personal **Accountability**

Respect for Others

Community **Responsibility**

“Client in the Center of the Room”



Research Based Criminogenic Needs

Factors that could increase criminal behavior

Antisociality

- Antisocial Attitudes/Beliefs
- Relationship Instability
- General Social Rejection
- Lack of Concern for Others
- Impulsivity
- Poor Problem Solving
- Negative Emotionality
- Negative Social Influences

Sexual Deviance

- Deviant Sexual Interest
- Emotional Congruence with Children
- Hostility Toward Women
- Sexual Drive and Preoccupation
- Sexualized Coping

MSOP Treatment Phases

Phase I - Orientation, engagement, self-management

Phase II - Disclosure, identification of abuse patterns and schemas, skill acquisition, awareness of self and others

Phase III - Skill application, transitions, consistent utilization of pro-social coping strategies

DEPARTMENT OF HUMAN SERVICES

SDP/SPP Civil Commitment

Pre-admission to Commitment & Reduction in Custody to Discharge

Calynn Schuck | Deputy General Counsel
DCT General Counsel's Office

High Level Overview

Initial Civil Commitment – Courts IN Process

- DOC refers cases to county attorneys of incarcerated persons who may qualify for civil commitment
- County attorney decides whether to petition for commitment
- Bench trial, commitment as Sexually Dangerous Person and/or Sexual Psychopathic Personality

Reduction in Custody – Courts OUT Process

- 3 Types of Reduction in Custody Petitions: **Transfer** to a non-secure treatment facility, **provisional discharge**, and full **discharge**
- Special Review Board, Recommendation → Commitment Appeals Panel (CAP)
- CAP (3 judge panel) rules on petition to grant or deny
- DCT Executive Board can appeal ruling to MN Court of Appeals, to Supreme Court of MN

Pre-Petition Process

- The process usually starts when a person is finishing a criminal sentence for a predatory sex offense conviction.
- The Department of Corrections refers inmates who may qualify for civil commitment to the county where the individual was convicted.
- The county attorney reviews the individual's history and decides if they should file a petition with the state district court alleging that the person meets the criteria for civil commitment.
- About 1,100 sex offenders are released from prison each year. Of those, 15 to 20 are civilly committed on average.

After Filing of Petition

- A preliminary hearing is held within 72 hours
- The trial court orders an evaluation by an independent, court-appointed examiner
- The individual has a right to formal bench trial and to present evidence against the petition
- If the court finds by “clear and convincing evidence” that the person meets the criteria for civil commitment, it must send the person to a secure treatment facility.

Exception

The court **is not** required to commit the person to a secure treatment facility if the person establishes by clear and convincing evidence that:

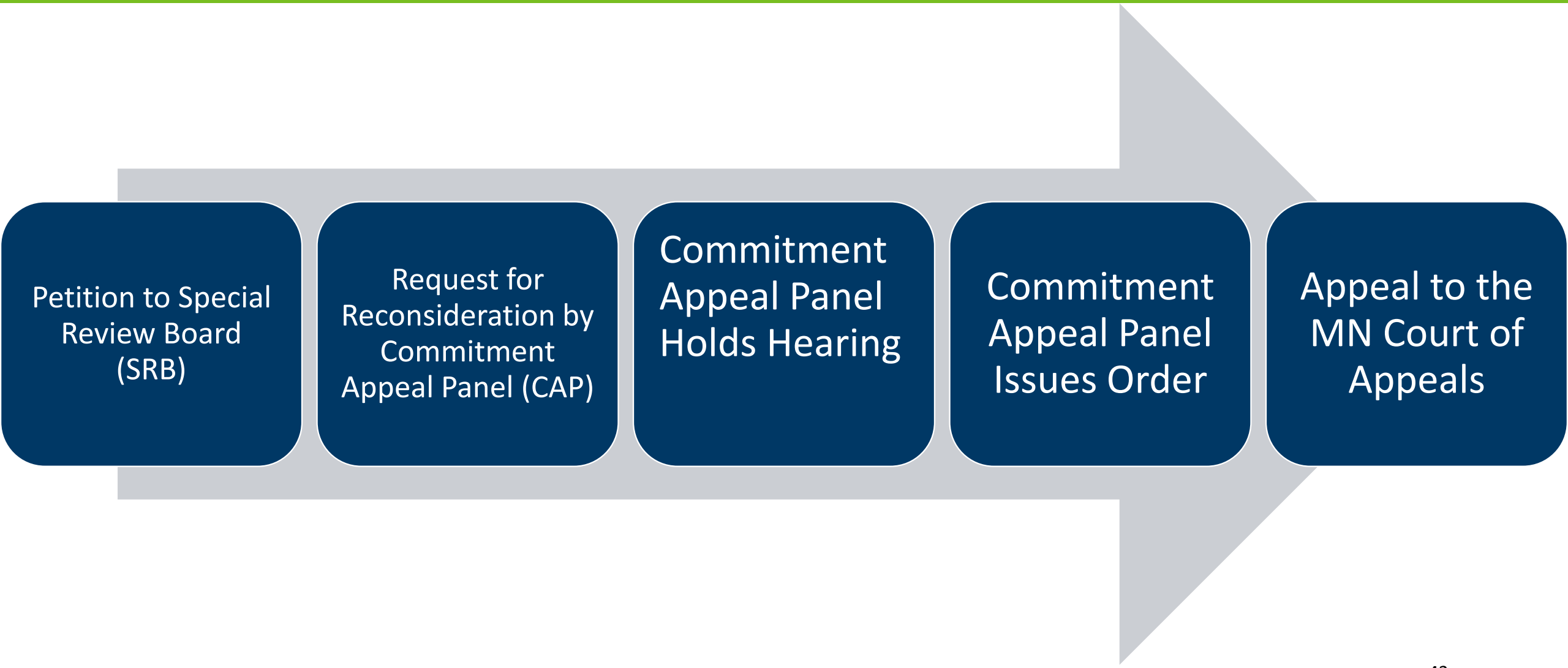
- A less restrictive sex offender treatment program is available
- The less restrictive treatment facility is willing to accept them
- And is consistent with the person's treatment needs and the requirements of public safety.

- Reality . . .

Court's Commitment to MSOP

- Once a petition is filed the individual is placed on "judicial hold status" during the court process
- Individuals subject to a judicial hold are placed either:
  - at MSOP, or
  - the Department of Corrections (limited time only)
- MSOP has no other involvement in the commitment process.
- The court commits the individual and issues its final order, the individual is admitted into MSOP.

After Admission: Court's Reduction in Custody Process



Reduction in Custody (RIC) Process

Petition to Special Review Board (SRB)

- Client (Client Attorney) submits a one-page request, and check boxes to indicate RIC and must contain signature
- SRB: three-member panel that makes a recommendation to deny or grant RIC
- SRB recommendation is filed with the Commitment Appeal Panel (CAP)

Reduction in Custody (RIC) Process

Request for Reconsideration by Commitment Appeal Panel (CAP)

- CAP – Panel of three District Court Judges
- Any Party – Executive Board, Client (Client's Attorney), or County
- 30 days after recommendation is issued
- Client's attorney must be reappointed by CAP after R&R is filed

Reduction in Custody (RIC) Process

Commitment Appeal Panel Holds Hearing

- If Request for reconsideration is filed – hearing is held
- *De Novo* Review
- Authority to appoint Independent Examiner
- Part 1/Part 2 Hearing – Burden Shifting Standard

Reduction in Custody (RIC) Process

Commitment Appeal Panel Issues Order

- Three types of Reduction in Custody
  - **Transfer** to a non-secure facility, Minn. Stat. §253D.29
  - **Provisional Discharge** into the community under supervision, Minn. Stat. §253D.30
  - **Full Discharge** from civil commitment, Minn. Stat. §253D.31
- Differing legal thresholds
- Order stayed for 15 days (Mn. Stat. §253D.28

Any Party can appeal to the MN Court of Appeals

Thank you!

Questions and Discussion

DCT Executive Board Updates and Strategic Planning Overview

Dan Storkamp, DCT External Relations Executive Director

DCT Advisory Committee Business

MN DCT Advisory Committee Business

Advisory Committee to review and discuss the following items:

- **Upcoming meeting cadence and agenda planning**
  - May meeting status
  - Recurring cadence for remaining meetings
  - Site visits
  - Priority agenda items
- **Additional Advisory Committee business**

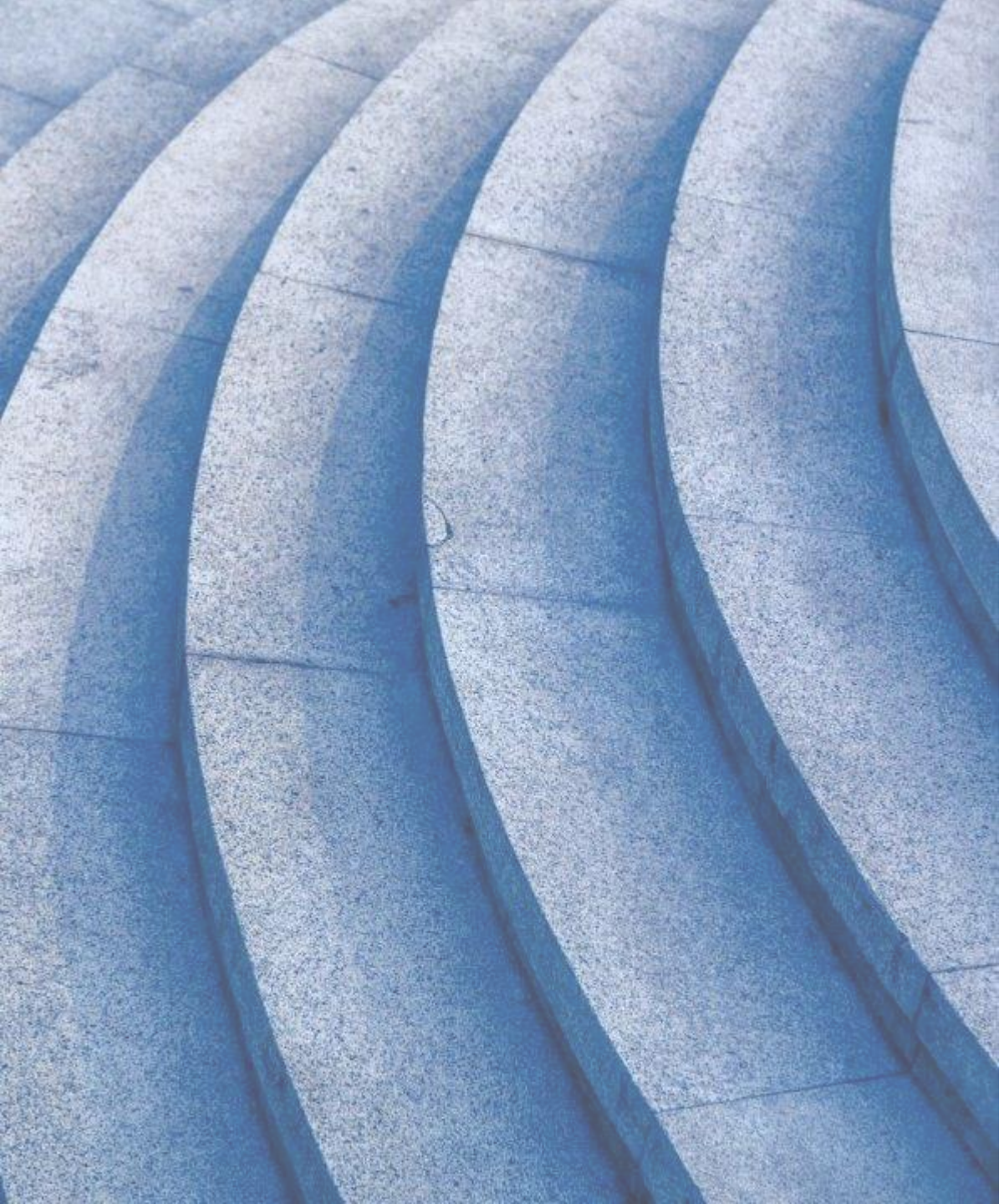
Open Comment Period

MN DCT Advisory Committee Meeting Open Comment

The Committee is dedicated to creating a consistent, fair and transparent method for members of the public to provide comments during meetings. The last 15 minutes of each meeting will be dedicated open comment.

- Members of the public who would like to comment must submit the form on the MN DCT Advisory Committee webpage.
- Comments are limited to topics within the DCT Advisory Committee's scope.
- Each speaker is allotted about three minutes to provide their comment.
- Public comment rules and expectations include:
  - Commenters must adhere to the amount of time allotted.
  - Commenters must address the committee respectfully. Personal attacks, profanity, or disruptive behavior are not permitted.
  - Presentations or materials are not allowed.
  - Comments must not contain any personal health information (PHI) or personally identifiable information (PII) about individuals who are associated with or have received care at DCT facilities.
- The Committee Chair or meeting staff may issue a warning or end a speaker's comment if rules are violated.
- During the public comment, the Advisory Committee will listen to comments and will not engage in discussion or provide responses.

Wrap Up and Next Steps



Wrap Up and Next Steps

- **Upcoming Meetings**
  - April 24, 2026, from 9:00-11:00 am CT
  - Information on the Advisory Committee and upcoming meetings available on the DCT Advisory webpage
- **Questions or concerns:** Reach out to Dani or Jill (email addresses in chat)

253D.30 PROVISIONAL DISCHARGE.

Subdivision 1. **Factors.** (a) A person who is committed as a sexually dangerous person or a person with a sexual psychopathic personality shall not be provisionally discharged unless the committed person is capable of making an acceptable adjustment to open society.

(b) The following factors are to be considered in determining whether a provisional discharge shall be granted:

(1) whether the committed person's course of treatment and present mental status indicate there is no longer a need for treatment and supervision in the committed person's current treatment setting; and

(2) whether the conditions of the provisional discharge plan will provide a reasonable degree of protection to the public and will enable the committed person to adjust successfully to the community.

Subd. 2. **Plan.** A provisional discharge plan shall be developed, implemented, and monitored by the executive director in conjunction with the committed person and other appropriate persons. The executive director shall, at least quarterly, review the plan with the committed person and submit a written report to the county attorneys of the county of commitment and the county of financial responsibility concerning the committed person's status and compliance with each term of the plan.

Subd. 3. **Review.** A provisional discharge pursuant to this chapter shall not automatically terminate. A full discharge shall occur only as provided in section 253D.31. The terms of a provisional discharge continue unless the committed person requests and is granted a change in the conditions of provisional discharge or unless the committed person petitions the special review board for a full discharge and the discharge is granted by the judicial appeal panel.

Subd. 4. **Voluntary readmission.** (a) With the consent of the executive director, a committed person may voluntarily return to a secure treatment facility from provisional discharge for a period of up to 60 days.

(b) If the committed person is not returned to provisional discharge status within 60 days of being readmitted to a secure treatment facility, the provisional discharge is revoked. The committed person shall immediately be notified of the revocation in writing. Within 15 days of receiving notice of the revocation, the committed person may request a review of the matter before the special review board. The special review board shall review the circumstances of the revocation and, after applying the standards in subdivision 5, paragraph (a), shall recommend to the judicial appeal panel whether or not the revocation shall be upheld. The board may recommend a return to provisional discharge status.

(c) If the provisional discharge has not been revoked and the committed person is to be returned to provisional discharge, no action by the special review board or judicial appeal panel is required unless the committed person's return to the community results in substantive change to the existing provisional discharge plan.

Subd. 5. **Revocation.** (a) The executive director may revoke a provisional discharge if either of the following grounds exist:

(1) the committed person has departed from the conditions of the provisional discharge plan; or

(2) the committed person is exhibiting behavior which may be dangerous to self or others.

(b) The executive director may revoke the provisional discharge and, either orally or in writing, order that the committed person be immediately returned to a secure treatment facility. A report documenting reasons for revocation shall be issued by the executive director within seven days after the committed person

is returned to the secure treatment facility. Advance notice to the committed person of the revocation is not required.

(c) The committed person must be provided a copy of the revocation report and informed, orally and in writing, of the rights of a committed person under this section. The revocation report shall be served upon the committed person, the committed person's counsel, and the county attorneys of the county of commitment and the county of financial responsibility. The report shall outline the specific reasons for the revocation, including but not limited to the specific facts upon which the revocation is based.

(d) An individual who is revoked from provisional discharge must successfully re-petition the special review board and judicial appeal panel prior to being placed back on provisional discharge.

Subd. 6. **Appeal.** Any committed person aggrieved by a revocation decision or any interested person may petition the special review board within seven days, exclusive of Saturdays, Sundays, and legal holidays, after receipt of the revocation report for a review of the revocation. The matter shall be scheduled within 30 days. The special review board shall review the circumstances leading to the revocation and shall recommend to the judicial appeal panel whether or not the revocation shall be upheld. The special review board may also recommend a new provisional discharge at the time of the revocation hearing.

History: *2010 c 300 s 26; 2011 c 102 art 1 s 3; 2013 c 49 s 7,22; 2024 c 79 art 6 s 14; 2025 c 38 art 3 s 49,50*

253D.29 TRANSFER.

Subdivision 1. **Factors.** (a) A person who is committed as a sexually dangerous person or a person with a sexual psychopathic personality shall not be transferred out of a secure treatment facility unless the transfer is appropriate. Transfer may be to a facility under the control of the executive board.

(b) The following factors must be considered in determining whether a transfer is appropriate:

(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 transfer can be accomplished with a reasonable degree of safety for the public.

Subd. 2. **Voluntary readmission to a secure treatment facility.** (a) After a committed person has been transferred out of a secure treatment facility pursuant to subdivision 1 and with the consent of the executive director, a committed person may voluntarily return to a secure treatment facility for a period of up to 60 days.

(b) If the committed person is not returned to the secure treatment facility to which the person was originally transferred pursuant to subdivision 1 within 60 days of being readmitted to a secure treatment facility under this subdivision, the transfer to the secure treatment facility under subdivision 1 is revoked and the committed person shall remain in a secure treatment facility. The committed person shall immediately be notified in writing of the revocation.

(c) Within 15 days of receiving notice of the revocation, the committed person may petition the special review board for a review of the revocation. The special review board shall review the circumstances of the revocation and shall recommend to the judicial appeal panel whether or not the revocation shall be upheld. The special review board may also recommend a new transfer at the time of the revocation hearing.

(d) If the transfer has not been revoked and the committed person is to be returned to the facility to which the committed person was originally transferred pursuant to subdivision 1 with no substantive change to the conditions of the transfer ordered pursuant to subdivision 1, no action by the special review board or judicial appeal panel is required.

Subd. 3. **Revocation.** (a) The executive director may revoke a transfer made pursuant to subdivision 1 and require a committed person to return to a secure treatment facility if:

(1) remaining in a nonsecure setting will not provide a reasonable degree of safety to the committed person or others; or

(2) the committed person has regressed in clinical progress so that the facility to which the committed person was transferred is no longer sufficient to meet the committed person's needs.

(b) Upon the revocation of the transfer, the committed person shall be immediately returned to a secure treatment facility. A report documenting reasons for revocation shall be issued by the executive director within seven days after the committed person is returned to the secure treatment facility. Advance notice to the committed person of the revocation is not required.

(c) The committed person must be provided a copy of the revocation report and informed, orally and in writing, of the rights of a committed person under this section. The revocation report shall be served upon the committed person and the committed person's counsel. The report shall outline the specific reasons for the revocation including, but not limited to, the specific facts upon which the revocation is based.

(d) If a committed person's transfer is revoked, the committed person may re-petition for transfer according to section 253D.27.

(e) Any committed person aggrieved by a transfer revocation decision may petition the special review board within seven days, exclusive of Saturdays, Sundays, and legal holidays, after receipt of the revocation report for a review of the revocation. The matter shall be scheduled within 30 days. The special review board shall review the circumstances leading to the revocation and, after considering the factors in subdivision 1, paragraph (b), shall recommend to the judicial appeal panel whether or not the revocation shall be upheld. The special review board may also recommend a new transfer out of a secure treatment facility at the time of the revocation hearing.

History: *2010 c 300 s 26; 2011 c 102 art 1 s 1,2; 2013 c 49 s 7,22; 2024 c 79 art 6 s 11-13; 2025 c 38 art 3 s 46-48*

253D.31 DISCHARGE.

A person who is committed as a sexually dangerous person or a person with a sexual psychopathic personality shall not be discharged unless it appears to the satisfaction of the judicial appeal panel, after a hearing and recommendation by a majority of the special review board, that the committed 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 treatment and supervision.

In determining whether a discharge shall be recommended, the special review board and judicial appeal panel shall consider whether specific conditions exist to provide a reasonable degree of protection to the public and to assist the committed person in adjusting to the community. If the desired conditions do not exist, the discharge shall not be granted.

History: *2010 c 300 s 26; 2013 c 49 s 7,22; 2018 c 194 s 2*