MINNESOTA DIRECT CARE AND TREATMENT ADVISORY COMMITTEE MEETING MINUTES

Meeting Information

- **Date and Time:** Friday, June 26, 2026, from 9:30-11:15 am CT
- **Location:** In-person location at Moose Lake, 1111 Highway 73, Moose Lake, MN 55767 for Advisory Committee members and a virtual meeting available via Zoom for other attendees
- **Direct Care and Treatment (DCT) Advisory Committee Attendees:** Chair Dave Baker; Vice Chair Bianca Virnig; Commissioner Tara Jebens-Singh; Marcus Schmit; Jessica Langhorst; and Jim Postier
- **DCT Advisory Committee Facilitators:** Jill Kemper and Danielle Swanson, Health Management Associates (HMA)
- **Speakers:** Nancy Johnston, MSSW, Executive Director of the Minnesota Sex Offender Program (MSOP); Jannine Hébert MA, LP, MSOP Executive Clinical Director

Meeting Summary

- **Welcome**
    - Chair Dave Baker welcomed members to the June MN DCT Advisory Committee meeting at the Moose Lake MSOP facility before turning the time over to the MSOP speakers to present on the MSOP facility and treatment programs.
    - Nancy Johnston, MSSW, Executive Director, MSOP also welcomed the Advisory Committee to MSOP and explained that, while she had previously provided a broader overview of MSOP at the March 2026 Advisory Committee meeting (meeting summary available here), the purpose of this meeting is to focus more deeply on treatment, including what MSOP provides to clients at Moose Lake and St. Peter. Johnston also reiterated that, following the meeting, Committee members would tour the Moose Lake facility in two groups and would have an opportunity to speak with clients at different points in treatment, including clients from Moose Lake and clients from Community Preparation Services (CPS).
- **Presentation: Quality and Compliance**
    - Jannine Hébert MA, LP, MSOP Executive Clinical Director, provided an overview of the program's treatment philosophy, client population, and treatment approach. (*Note: information found on slides is not repeated in the minutes below - see slides 3-36 below for those details*.)

- Hébert provided context regarding the population served by MSOP and noted that individuals committed to the program have already been determined by the courts to present a high risk of reoffending. Hébert explained that clients often present with complex and overlapping treatment needs, including sexual deviance, antisocial thinking patterns, personality disorders, mental health concerns, trauma histories, cognitive limitations, and the effects of long-term institutionalization. As a result, treatment planning is individualized and designed to address each client's unique combination of strengths, challenges, and treatment targets rather than relying on a one-size-fits-all approach.
- Hébert also described MSOP's treatment philosophy and organizational structure, noting that treatment extends beyond formal clinical programming and involves collaboration across operations and clinical staff. Hébert explained that MSOP intentionally relies on a multidisciplinary approach and that treatment staff, security staff, recreational staff, education staff, health services staff, and others all contribute observations that help inform assessment of client progress. Hébert emphasized that no single staff member determines whether a client is progressing in treatment and that treatment teams gather information from multiple settings and perspectives when evaluating treatment advancement and readiness for additional responsibility.
- During the presentation, Hébert discussed the impact of long-term institutionalization and described it as an important treatment consideration. Hébert explained that many clients have spent significant periods of time in correctional and secure treatment settings where day-to-day decisions are routinely made for them. As a result, treatment includes opportunities to practice decision-making, autonomy, accountability, and community responsibility. Hébert noted that MSOP works to build these skills over time by creating opportunities for clients to exercise increasing levels of personal responsibility while continuing to address offense-related treatment needs.
- Hébert reviewed the theoretical foundations that guide treatment at MSOP and described treatment as a process of helping clients initiate, engage in, and maintain meaningful change over time. Hébert explained that treatment is informed by research related to stages of change and risk-needs-responsivity principles and that interventions are designed to address factors associated with sexual offending and future risk. Hébert noted that treatment focuses not only on addressing past behaviors, but also on helping clients build insight, strengthen coping strategies, develop healthier decision-making processes, and apply those skills consistently in a variety of settings.
- Hébert described MSOP's phased treatment structure and explained that treatment expectations and goals evolve as clients progress. Early stages of treatment focus heavily on engagement, accountability, behavioral stability, and development of a therapeutic relationship, while later stages increasingly emphasize examination of offense patterns, identification of risk factors, understanding pro-offending beliefs, development of coping strategies, and application of skills across settings. Hébert also

described the matrix card system used throughout MSOP, which provides a common treatment framework and shared language that can be used by both clients and staff when discussing treatment goals and progress.

- Committee members then engaged in an open discussion following the presentation, summarized below:
  - Committee members asked several questions regarding treatment participation and program requirements. In response, Hébert explained that approximately 85 percent of clients consent to participate in treatment and attend core treatment groups, although motivation and engagement vary across individuals. Hébert further noted that clients who choose not to participate in formal treatment continue to have assigned therapists, receive treatment reports, and remain part of the broader treatment environment. Committee members also asked about treatment intensity, and Hébert explained that treatment programming is tailored to individual needs and stage of treatment rather than being driven by a specific number of treatment hours required by statute or professional standards.
  - Committee members asked how MSOP evaluates treatment progress. Hébert explained that treatment teams rely on multiple sources of information, including client disclosures, observed behavior, formal assessments, and observations documented by staff throughout the facility. Hébert emphasized that progress is evaluated based not only on what clients say during treatment groups, but also on how they behave in other settings, including employment assignments, recreational activities, housing units, and interactions with staff and peers. Hébert highlighted the role of communication logs and treatment reports in helping clinicians identify behavioral patterns and assess whether clients are consistently applying treatment concepts across settings.
  - Committee members discussed emotional regulation and observed that some treatment expectations appeared demanding when compared with the general population. In response, Hébert emphasized that treatment goals are not intended simply to make clients more emotionally healthy or well-rounded. Rather, Hébert explained that treatment targets are directly connected to factors associated with sexual offending behavior and risk for future harm. Hébert noted that emotional regulation deficits can contribute to offending behavior and that treatment focuses on addressing those specific risk-related concerns.
  - Committee members asked about opportunities for treatment before individuals arrive at MSOP and whether correctional facilities provide similar programming. Hébert explained that correctional sex offender treatment programs and community-based treatment providers often operate using many of the same research-based principles that inform MSOP programming.

However, Hébert emphasized that correctional facilities are primarily designed around containment, while MSOP is designed around treatment. Hébert noted that participation in treatment while incarcerated is voluntary and that many clients who ultimately arrive at MSOP may have declined or not fully engaged in previous treatment opportunities. Discussion also highlighted that only a small percentage of individuals released from corrections ultimately enter the civil commitment system.

- Committee members questioned how MSOP distinguishes meaningful treatment progress from simple conformity to institutional expectations. In response, Hébert acknowledged that behavioral compliance and conformity can be important early steps in treatment, particularly for clients who have struggled with authority, accountability, and behavioral control. Hébert explained that treatment teams ultimately look for evidence of deeper insight, personal accountability, understanding of offense patterns, and the ability to apply treatment concepts consistently across settings. Hébert noted that while clients may temporarily conform to expectations, treatment teams evaluate long-term behavior patterns and rely on information gathered across settings to distinguish genuine progress from superficial compliance.
- Committee members asked about the relationship between treatment progression and liberty status, including movement to CPS, provisional discharge, and full discharge. Hébert explained that treatment progression and legal status are related but distinct processes. Hébert noted that treatment staff provide reports, assessments, and information to the courts, but do not make legal decisions regarding release or custody status. Instead, courts determine whether clients may move to less restrictive settings, while treatment teams continue to focus on clinical progress and risk reduction. Hébert also highlighted that clients may reside in different settings while remaining at various phases of treatment.
- Committee members also asked whether housing units are organized according to treatment phase. Hébert explained that most clients are intentionally housed in mixed-treatment environments because exposure to peers at various stages of treatment can encourage growth, accountability, and treatment-related discussions. Hébert noted that specialized units exist for individuals with medical, behavioral, mental health, or cognitive needs; however, most clients live in mixed-phase environments designed to encourage interaction across treatment stages.
- Committee members asked what Advisory Committee members should focus on during the facility tour. Hébert emphasized transparency and encouraged members to use the opportunity to gather information from multiple perspectives. Committee members highlighted the importance of comparing

information presented by program leadership with perspectives received from clients, families, and other stakeholders as members fulfill their advisory role and develop recommendations related to DCT operations and policy.

- The presentation concluded with an extended discussion regarding civil commitment, release processes, and client petitions for reductions in custody. Committee members asked questions about referrals from corrections, county involvement, court review processes, and petition timelines. Hébert and MSOP leadership described the multiple review points involved in civil commitment decisions and explained the roles of counties, the Special Review Board, the three-judge panel, and the courts in evaluating requests for changes in custody status. Committee members expressed particular interest in understanding petition timelines (approximately two years currently), barriers to progression through the review process, and potential opportunities to improve efficiency while maintaining public safety. Discussion also focused on the amount of time often required for petitions to move through the review system and ongoing conversations regarding possible changes to streamline portions of the process. MSOP staff emphasized that they had proposed changes to the process previously to eliminate one of the review process steps, but policy change had not gained traction at the legislative level, largely due to the subject matter.

- **DCT Advisory Committee Business**
  - Chair Baker opened the meeting for discussion on upcoming meeting dates. Chair Baker reminded members that the July meeting had been canceled and that the next meeting would take place in August at the St. Peter facility. DCT staff noted that planning for the St. Peter tour was underway and that the format would be similar to the Moose Lake meeting, including a program overview followed by a tour. Committee members will receive additional information about the location, time, agenda, and security logistics closer to the event.
  - Chair Baker reminded Committee members about the option for travel/mileage reimbursement, reminding them that they would need to complete the DCT reimbursement form (available by contacting Jill, Dani, or Dan after the meeting). Additional approval forms related to the site visit will also be sent to Committee members ahead of the tour.
  - Finally, Chair Baker invited members to identify any future agenda items they would like the Committee to consider for upcoming meetings.
- **Open Public Comment**
  - Chair Baker introduced the public comment segment of the agenda and welcomed one commenter who had previously signed up to comment. The comment summary is provided below.

        - William Dobbs provided comments regarding the MSOP. Dobbs stated that many Moose Lake clients were interested in sharing their perspectives with the Advisory Committee and expressed concern that discussions to date had primarily reflected the views of MSOP administration. Dobbs encouraged Advisory Committee members to seek information directly from clients during the site visit and to engage with a broad range of individuals when assessing the program, not just those chosen by MSOP staff. Dobbs specifically encouraged members to ask clients about their experiences in treatment, their understanding of treatment progression, their perspectives on the release process, and the impact of long-term confinement. Dobbs noted that, in his view, understanding the experiences of current clients is important for obtaining a comprehensive picture of the program.
        - Dobbs also raised concerns regarding client length of stay within MSOP. He stated that many individuals have spent extended periods of time in the program (Dobbs stated that nearly half of the individuals inside have been confined for 16 years or longer) and encouraged the Committee to explore how treatment progression relates to release opportunities. Dobbs suggested that members discuss with clients their understanding of what is required to advance through treatment and how they perceive their ability to progress toward reduced restrictions or release. Dobbs asserted that feelings of hopelessness can develop among clients who perceive limited opportunities for advancement and encouraged the Committee to further examine this issue.
        - Dobbs further encouraged the Committee to review information related to releases, mortality rates, and overall outcomes within MSOP. Dobbs encouraged Committee members to inquire further about number and names of individuals who have died within the facility. Dobbs referenced prior reports and public analyses relating to efficacy the program (e.g., Mitchell Hamline School of Law report on MSOP). Dobbs urged Committee members to continue evaluating whether MSOP is effectively balancing public safety, treatment objectives, and client rights and noted potential conflicts of interest with recent public awards. Dobbs concluded by encouraging the Advisory Committee to continue its independent review of the program and described the Committee as an important mechanism for oversight and accountability.
    - Chair Baker thanked the commenter and transitioned to the meeting close.
- **Wrap Up and Next Steps**
    - Chair Baker 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 August 26, 2026, at the St. Peter facility (see details above).

Minnesota Direct Care and Treatment:
Advisory Committee Meeting

JUNE 26, 2026

MOOSE LAKE, 1111 HIGHWAY 73, MOOSE LAKE, MN 55767

Today's Agenda

1. Welcome
2. Presentation: Minnesota Sex Offender Program
3. DCT Advisory Committee Business
4. Open Public Comment
5. Wrap Up and Next Steps

DIRECT CARE AND TREATMENT

DCT Advisory Committee Presentation

Jannine Hébert MA, LP | MSOP Executive Clinical Director

ONE program – **TWO** campuses – **THREE** sites

Census as of 6/16/26

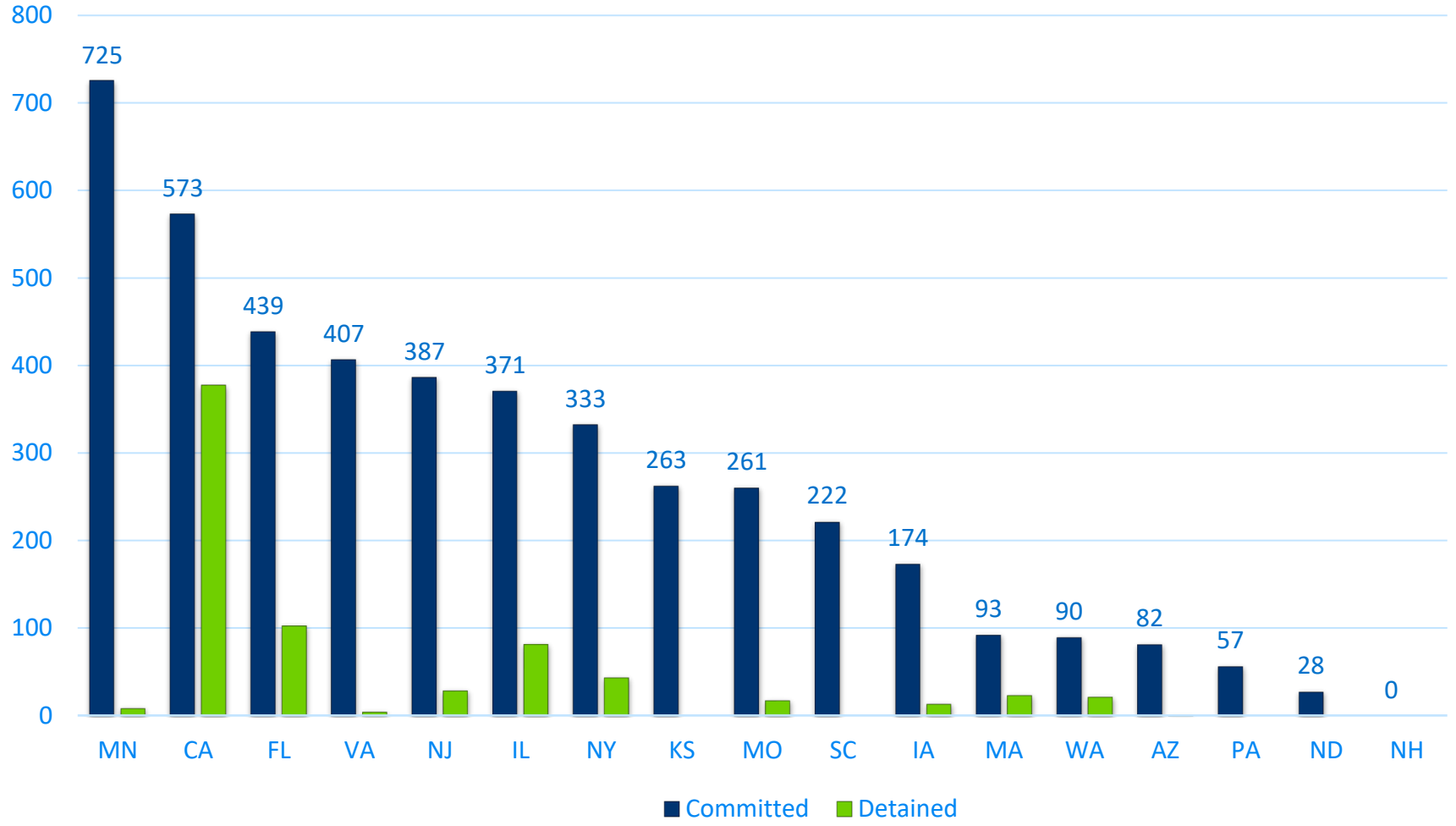
- Moose Lake - 417
- St. Peter - 204
- CPS - 139

*Effective 6/16/2026

Treating adults who have engaged in sexual abuse

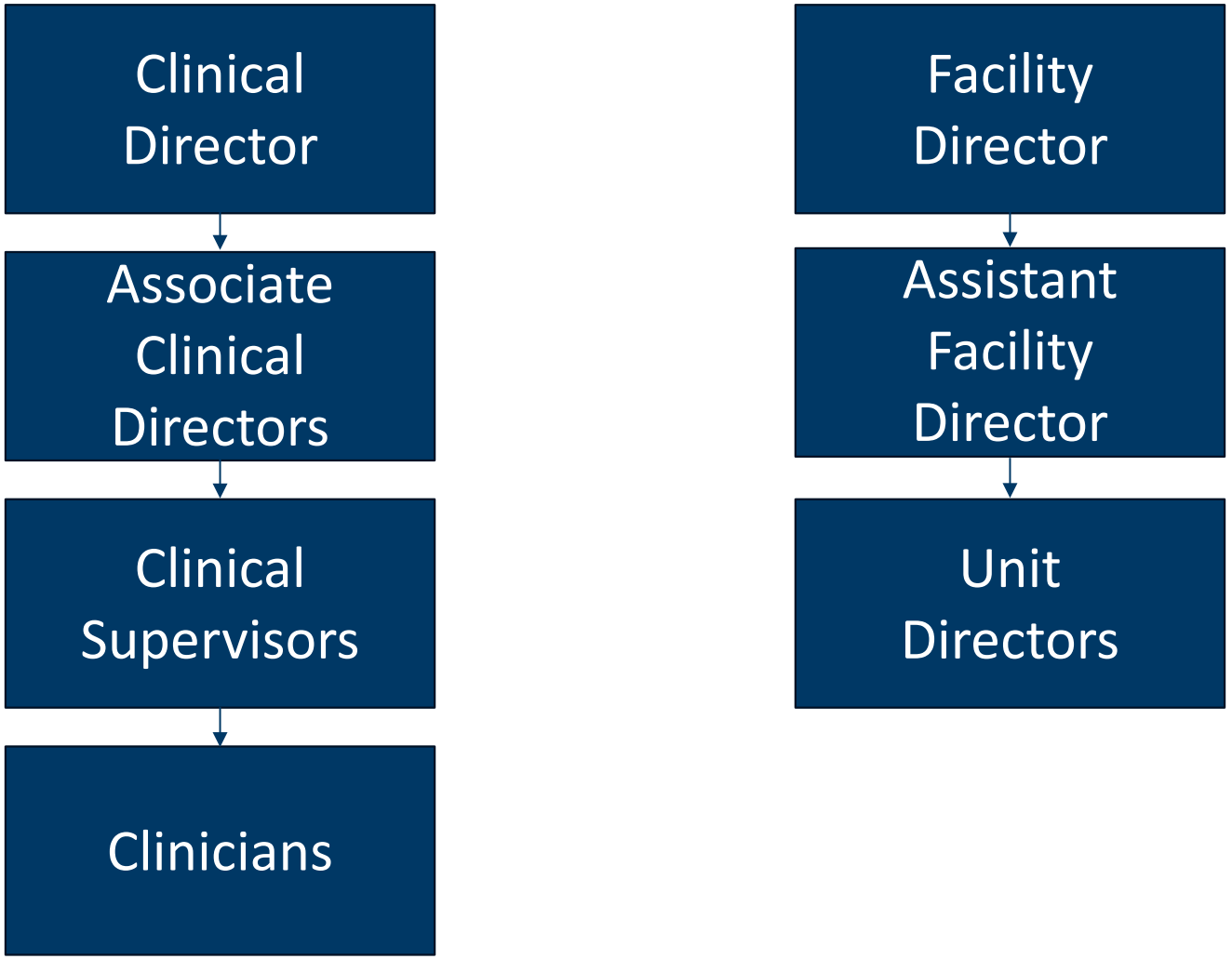
- Generally high risk, high needs
- Continuum of behaviors. Range of pathology and risk.
- Range of management tools and treatment interventions-based on individual risk, needs, progress and strengths
- Identified professional field of study based in research with emerging theories and best practices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

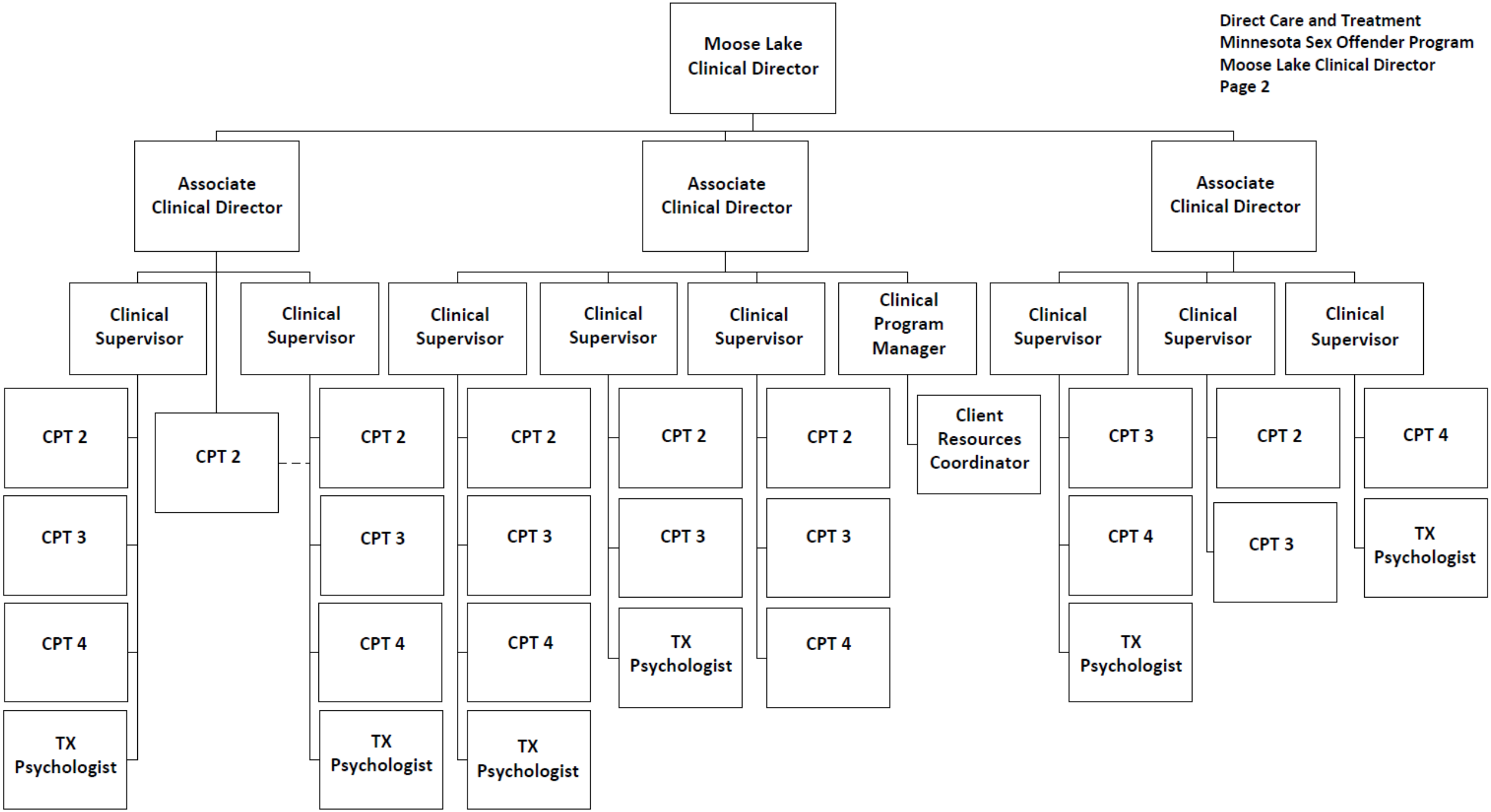
SVP Civil Commitment Census by State



N=17/23

MSOP facility staffing structure




Moose Lake Clinical Director
Associate Clinical Director
Associate Clinical Director
Associate Clinical Director
Clinical Supervisor
Clinical Supervisor
Clinical Supervisor
Clinical Supervisor
Clinical Supervisor
Clinical Program Manager
Clinical Supervisor
Clinical Supervisor
Clinical Supervisor
CPT 2
CPT 3
CPT 4
TX Psychologist
CPT 2
CPT 2
CPT 3
CPT 4
TX Psychologist
CPT 2
CPT 3
CPT 4
TX Psychologist
CPT 2
CPT 3
TX Psychologist
CPT 2
CPT 3
CPT 4
Client Resources Coordinator
CPT 3
CPT 4
TX Psychologist
CPT 2
CPT 3
CPT 4
TX Psychologist

Treatment

MSOP: Uniquely Challenging Clinical Population

- Generally, individuals with higher risk for sexual re-offense
- Present with patterns of sexual deviance
- Personality disorders (antisocial, narcissism, borderline etc.)
- Psychopathy/Antisociality
- Institutionalization

MSOP population – Diagnoses

- Clients with at least one substance use disorder: 481 (65.5%; N=734)
- Clients with an acute mental health disorder (any of below): 352 (48.0%)
  - Trauma-related: 82 (11.2%)
  - Mood/depressive: 231 (31.5%)
  - Anxiety/OCD: 60 (8.2%)
  - Psychotic: 30 (4.1%)
- Clients with at least one personality disorder: 657 (89.5%)
- Clients with at least one paraphilic disorder: 666 (90.7%)
  - Sexual Sadism Disorder: 52 (7.1%)
  - Pedophilic Disorder: 333 (45.4%)

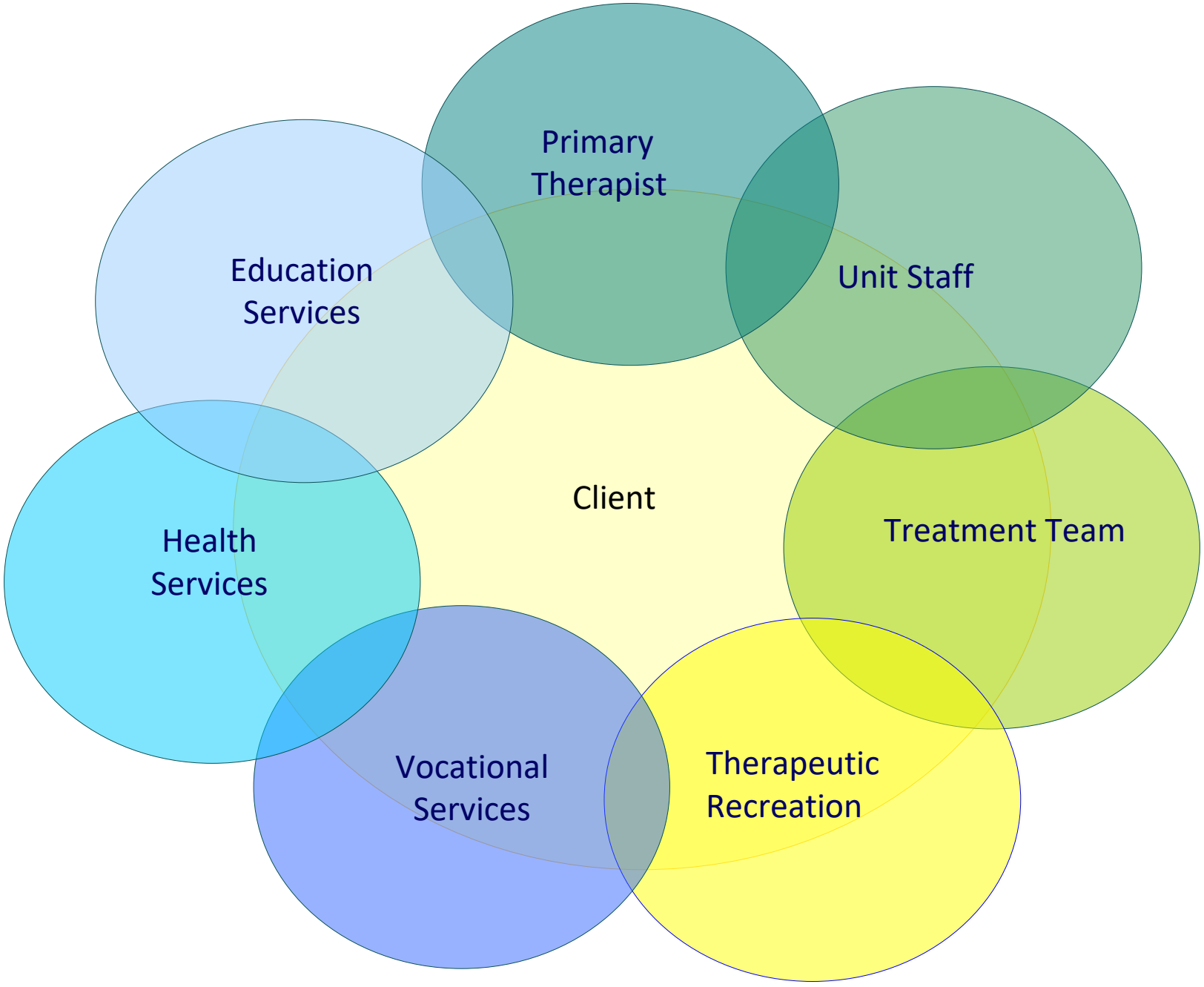
Source: Phoenix active diagnoses (August 2024)

MSOP Principles

Personal **Accountability**

Respect for Others

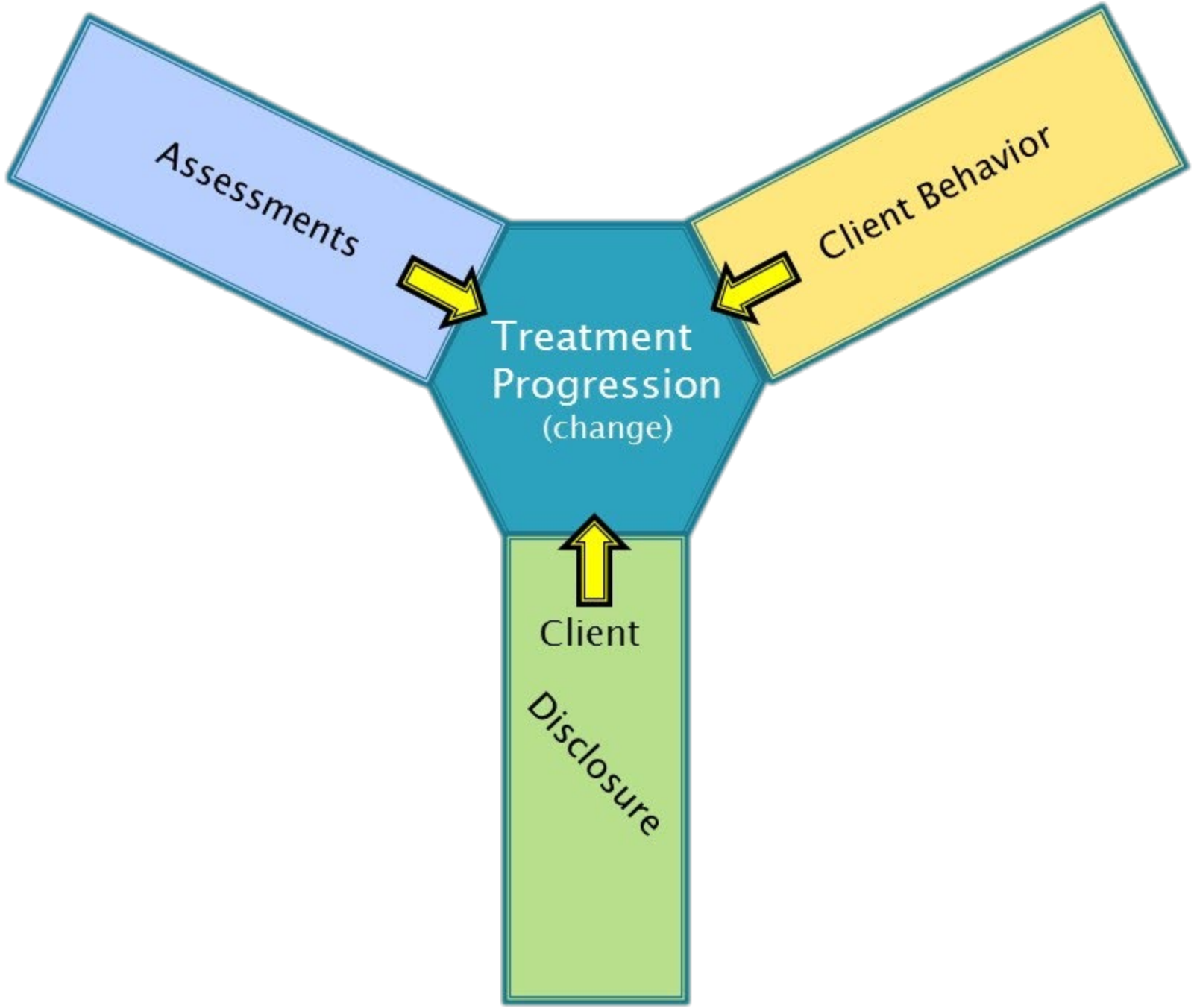
Community **Responsibility**


Primary Therapist
Education Services
Unit Staff
Client
Health Services
Treatment Team
Vocational Services
Therapeutic Recreation

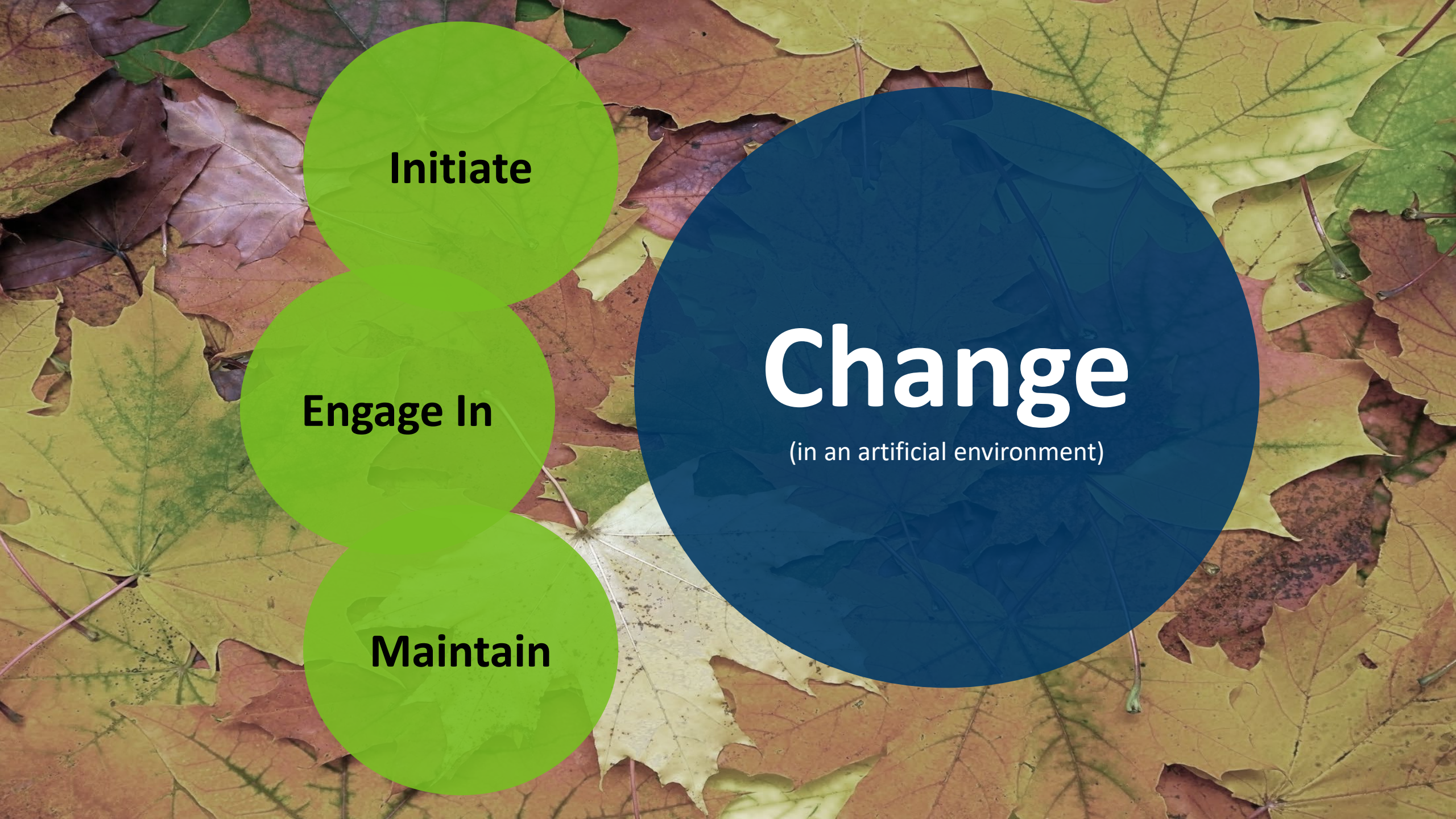
MSOP Client Factors Informing Treatment

MSOP Comprehensive Treatment

- **Sex offense specific treatment**
  - Core groups/psychoeducation groups
- **Individual treatment**
  - Treatment psychologists
- **Specialty Programming**
  - Arousal management
  - Sexual compulsivity
- **Clinical Programming**
  - Vocational, educational, therapeutic recreation


Assessments
Client Behavior
Treatment
Progression
(change)
Client
Disclosure

TREATMENT = CHANGE


Initiate
Engage In
Maintain
Change
(in an artificial environment)


Content
Process

Foundational Research Informing Treatment & Best Practices

Stages of change

Prochaska, J.O.,& Velcer, W.F. (1997). The transtheoretical model of health beahvior change. *American Journal of Health Promotion,* 12(1), 38-48

Risk Needs Responsivity

Bonta, J., & Andrews, D. A. (2007). *Risk-need-responsivity model for offender assessment and rehabilitation* (User Report No. 2007-06). Public Safety Canada.

Stages of Change

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

Risk Needs Responsivity

Who, What, How

- ***Risk Principle***-Match the level (intensity) of service with the client's risk to reoffend **(who)**

- ***Needs Principle***-Target criminogenic needs in treatment **(what)**

- ***Responsivity Principle***-Provide the treatment in a style and mode that is responsive to the client's learning style and ability **(how)**

Research Based Criminogenic **Needs** (RNR)

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

Phase I
(stages of change
pre-contemplation/early contemplation)

Clients

- High need, low responsivity
- Externally focused
- Testing of parameters
- Resistant to personal accountability/change
- Immediate gratification
- Highly litigious
- Less internal controls/need for external controls, cues

Treatment Targets

- Establish therapeutic relationship/trust
- General self-management
- Maintain behavioral control
- Conform to the rules of the program
- Identify treatment interfering behaviors/attitudes

Phase II
(stages of change
contemplation, preparation, action)

Clients

- Recognize problem(s) exist
- Range of treatment motivation
- Reliance on therapeutic relationship
- Maintain behavioral control, even under stress of treatment
- Focus shifts from external to internal
- Recognition of offending capability/expressed desire to change

Treatment Targets

- Identify patterns of sexually abusive behavior
- Identify motivation in sexual offending/risk factors
- Identify pro-offending beliefs/distortions of self and other
- Identify sexual deviancy
- Develop strategies/build strengths for future prosocial life

Phase III (Stages of Change maintenance)

Clients

- Developing familiarity with new identity
- Practicing skills: relational, communication, living
- Mentoring peers
- Establish and maintain internal controls

Treatment Targets

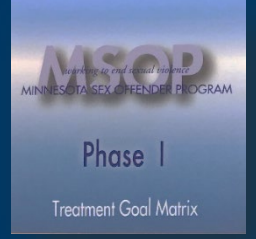
- Continued deinstitutionalization
- Generalize treatment gains across settings
- Maintain meaningful change
- Preparation for reintegration

MSOP Matrix Factors
(treatment targets)

- Group behavior
- Attitude toward change
- Self-monitoring
- Thinking errors
- Pro-social problem solving

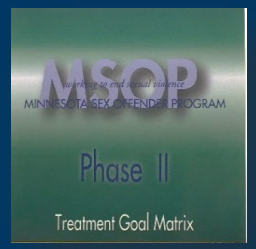
- Emotional regulation
- Interpersonal skills
- Sexuality
- Cooperation with rules/supervision
- Life Enrichment
- Healthy Lifestyle


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



MSOP Emotional Regulation: Phase I

- Understand feelings. Know that it is okay to have feelings.
- Express feelings in the right time, place, and manner. Do not stuff feelings and do not go overboard with them.
- Keep your behavior in check when you have strong emotions.
- Ask for help when you have a hard time recovering from difficult or intense emotions.



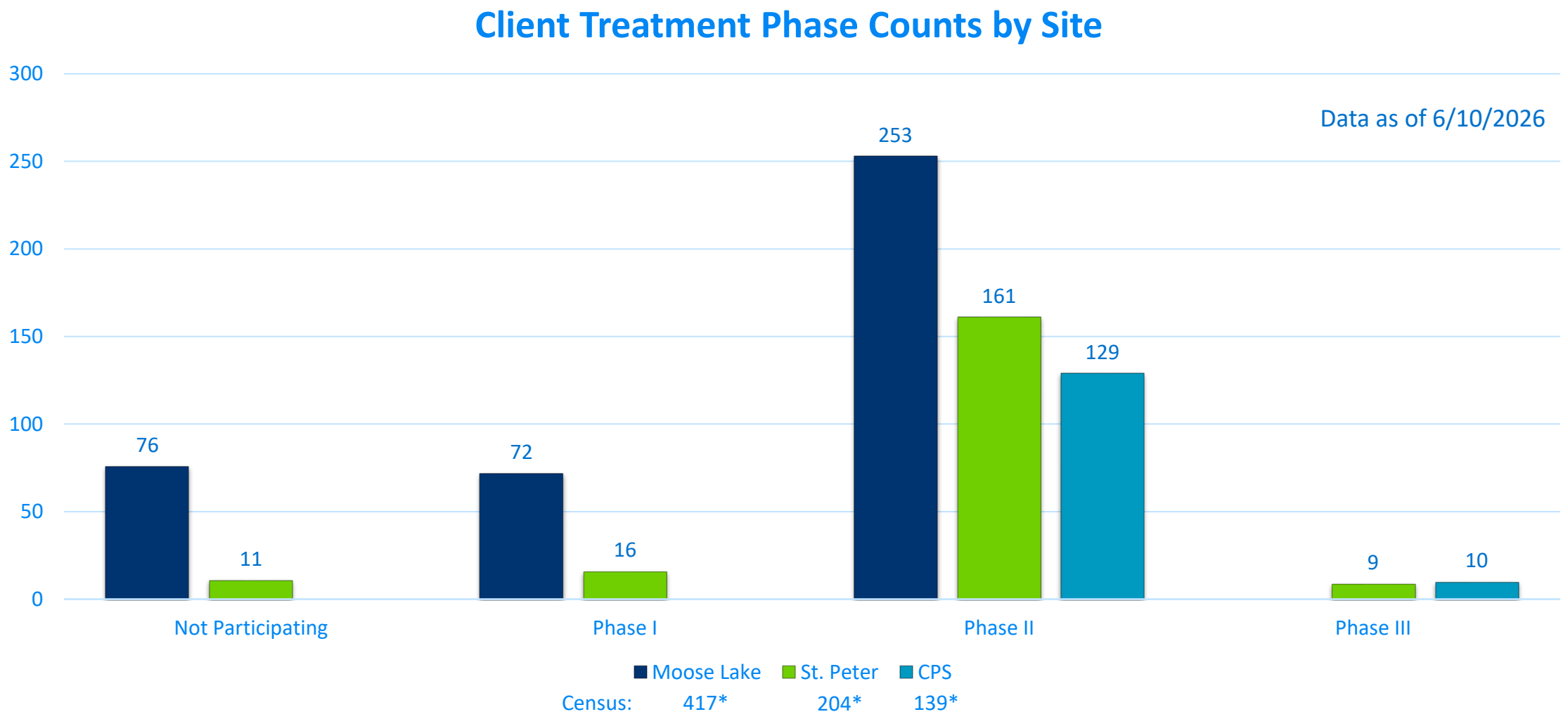
MSOP Emotional Regulation: Phase II

- Know your feelings and accept them. Do not deny having them. Do not stuff them or make yourself think they are much bigger than they really are.
- Know what to do with your feelings. Try new ways to handle and express them.
- Understand how feelings relate to your offense patterns and to the part of you capable of sexual abuse.
- Take charge of your emotions. Be able to manage feelings without being prompted.
- Learn to recover quickly when you have strong feelings.

MSOP Emotional Regulation: Phase III

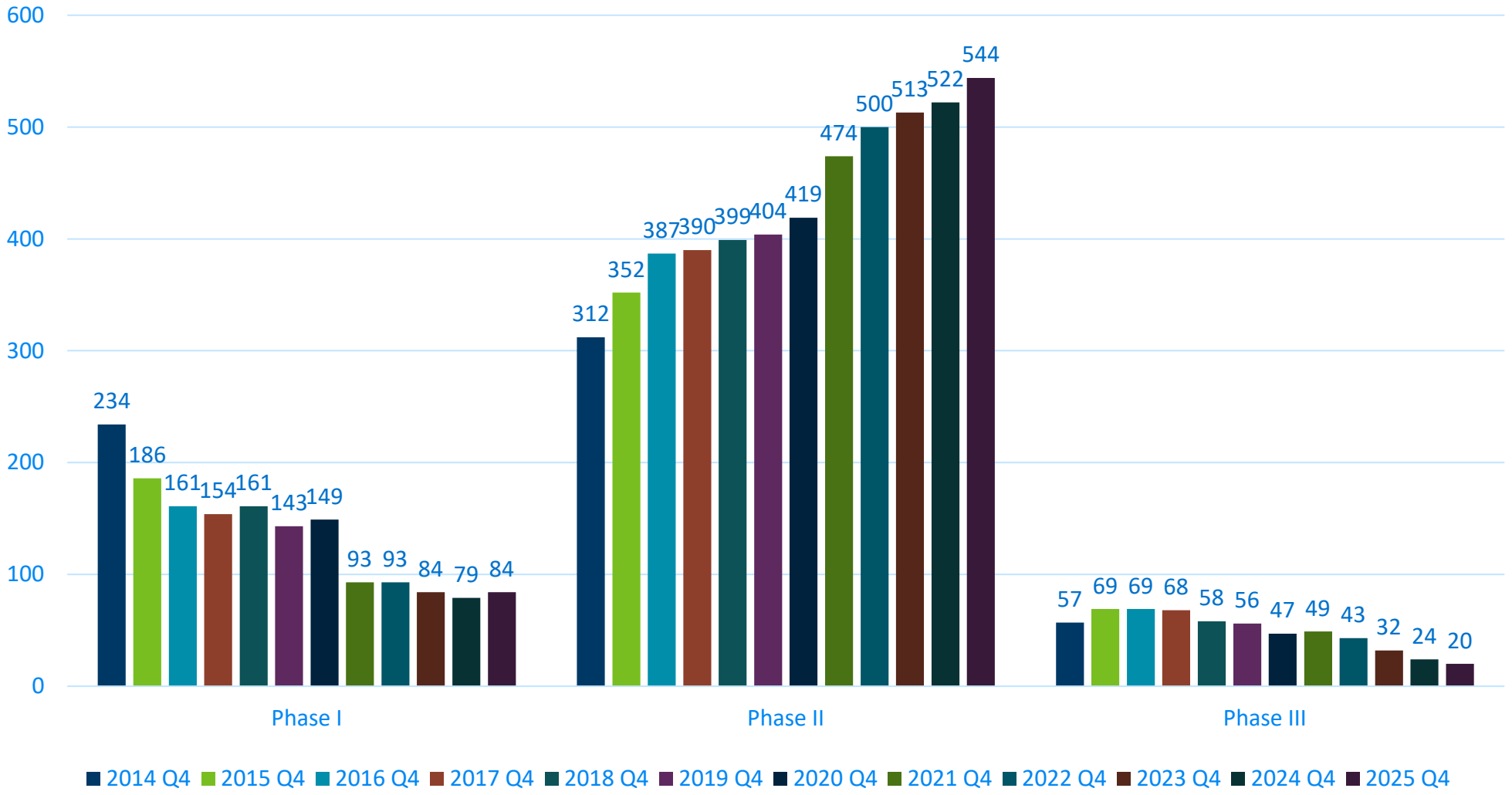
- Be aware of your feelings during new activities, when you have more freedom, choices and temptations.
- Be willing to talk about your feelings, even when it is hard to do.
- Cope with events in a way that shows a healthy range of feelings that are appropriate to time, place and manner, no matter where you are or what you are doing.
- Help peers to notice and cope with their feelings.

MSOP Treatment Phase by Site



*Census data from 6/16/2026

Client Phase Comparison
Q4 2014 to Q4 2025*



*Does not include Admission/Assessment and clients not participating in treatment

DIRECT CARE AND TREATMENT

Thank You!

Jannine Hébert MA,LP

Jannine.hebert@state.mn.us

DCT Advisory Committee Business

MN DCT Advisory Committee Business

Advisory Committee to review and discuss the following items:

- **Upcoming meeting cadence and agenda planning**
  - Reminder: No July Advisory Committee Meeting
  - Next Meeting: August 26, 2026 (St. Peter)
- **Additional Advisory Committee business**

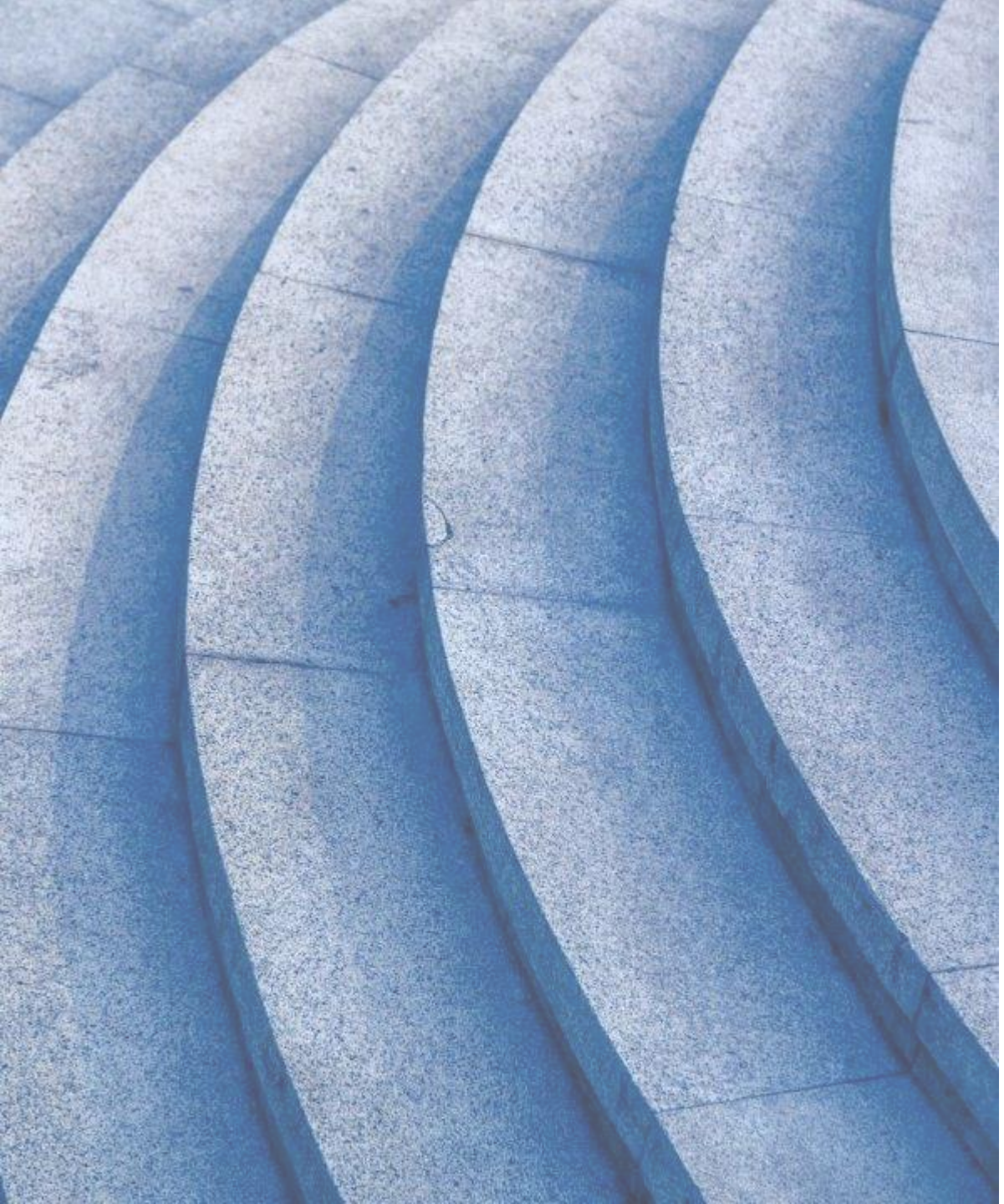
Open Comment Period

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**
  - August 26, 2026
  - 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)