STATE OF MINNESOTA

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April26, 2012

The Honorable Jeffrey J. Keyes
Magistrate Judge, District of Minnesota
United States District Court
646 Warren E. Burger Federal Courthouse
316 North Robert Street
St. Paul, MN 55101

Re: *Kevin Scott Karsjens, et al. v. Lucinda Jesson, et al.*
United States District Court File No. 11-3659 (DWF/JJK)

Dear Judge Keyes:

On behalf of the Minnesota Sex Offender Program ("MSOP") and the Minnesota Department of Human Services ("Department"), and as provided for by prior Order of the Court [Doc. No. 275], the undersigned hereby submits for filing the following:

1. MSOP Program Evaluation Team Report ("MPET Report"), dated February 13, 2013;
2. MSOP's responses to the MPET Report, dated March 21, 2013;
3. Site Visit Report, dated December 27, 2012; and
4. MSOP's responses to the Site Visit Report, dated April 5, 2013.

Copies of these documents will also be publicly available on the Department's website.

Respectfully submitted,

STEVEN H. ALPERT
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Report on the Evaluation of Treatment Phase Progression at the Minnesota Sex Offender Treatment Program (MSOP)

To: The Honorable Jeffrey J Keyes
United States District Court
646 Warren E Burger Federal Courthouse
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From: MSOP Program Evaluation Team:

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Robert McGrath, M.A., McGrath Psychological Services, Middlebury, Vermont

William Murphy, Ph.D., University of Tennessee, Health Science Center, Memphis, Tennessee

Jill D. Stinson, Ph.D, East Tennessee State University, Johnson City, Tennessee

Re: *Karsjens et al. v. Jesson et al.*
Court File: Civ. No. 11-3659

Date: February 13, 2013

Pursuant to a November 9, 2012 court order in the above captioned case, the MSOP Program Evaluation Team ("Evaluation Team") has been charged with evaluating treatment phase progression at the Minnesota Sex Offender Treatment Program (MSOP).

The Court, in part, ordered the following:

> *The focus of the Evaluation Team is to address possible program issues associated with client treatment phase progression ("phase progression"). The Evaluation Team shall review the treatment records of clients who have been participating for at least 36 months in a treatment phase and who have not yet advanced to the next treatment phase. The records reviewed shall include a random sampling of the records of at least 10% or 15 clients, whichever is higher, to a maximum of 25% of those clients identified above (at the discretion of the Evaluation Team). The Evaluation Team's review is to supplement the annual program evaluation described in Minnesota Statutes, section 246B.03, subdivision 2.*
>
> *As part of the Evaluation Team's investigation of phase progression, it may consider any topic it deems related to phase progression, such as: adequacy of staffing levels and staff training,· the type and amount of treatment offered,· individual treatment record documentation,· individual treatment plan documentation,· the accuracy of client placement and progression within each treatment phase,· therapeutic environment, etc.*
>
> *No later than April 15, 2013, the Evaluation Team shall prepare and provide the MSOP Executive Director, the Court, and counsel for the parties in this litigation, with Findings and Recommendations on phase progression. The Evaluation Team shall also determine and include in its report a recommendation on the need, scope, and frequency of any future MSOP treatment program evaluation. These Findings and Recommendations on phase progression may be in addition to and reported separately from the annual program evaluation described in Minnesota Statutes, section 246B. 03, subdivision 2.*

Procedures

The Evaluation Team conducted the following activities.

1. The Evaluation Team reviewed five recent MSOP Program Site Visit Reports (2007, 2009, 2010, 2011, and 2012), which were conducted pursuant to Minnesota Statutes, section 246B.03, subdivision2 (2012). The Evaluation Team also reviewed the "MSOP Program Theory Manual" (January 2013 draft), "MSOP Clinician's Guide" (January 2013 draft), and recent MSOP Quarterly Reports.

2. Evaluation Team members Drs. Kunkle and Stinson toured the MSOP Moose Lake facility on January 24, 2013 and the St. Peter facility on January 25, 2013. The other Evaluation

Team members have served as Annual Evaluators and have visited the MSOP facilities on several occasions.

3. The Evaluation Team participated in a conference call with staff representing MSOP (Nancy Johnson, Jannine Hebert, Robin Vue-Benson, Leah Flygare, and Jessica Geil) on January 9, 2013, to review the purpose of the evaluation, identify the number of cases to be reviewed, and the content of the case files to be reviewed. Table 1 shows the number of clients, by program phase, who MSOP identified as being in the same phase of treatment for at least 36 months and the number and percent of clients in each phase of the program that were selected for review.

Table 1. Number and Percent of Clients by Phase Selected for Review

Program Phase	Clients in the Phase for at least 36 months	Number of clients selected for review	Percent of clients selected for review
I	172	20	12%
II	111	15	14%
III	25	15	60%
Total	308	50	16%

It was agreed that he Evaluation Team would conduct the review at MSOP administrative offices in St. Paul, MN, and that MSOP would prepare one hard copy of each case to be reviewed that would include the following: Special Review Board Treatment Reports, Risk Assessments, Polygraph Reports, Psychological and Sex Offender Assessments, Quarterly Treatment Reviews, Annual Treatment Progress Reports, Individual Treatment Plan, Administrative Restriction Reports, Protective Isolation Reports, Behavioral Expectations Reports, Hearing Findings Reports, Group and Individual Progress Notes, Petition for Commitment, Hold Order, Findings of Fact and Initial Commitment Order, SRB Petitions, SRB Findings of Fact and Recommendations, and Supreme Court Appeals Panel Papers (Judicial Panel Decisions).

4. The Evaluation Team met by conference call on February 1, 2013 to discuss the evaluation approach.

5. The Evaluation Team reviewed client files and discussed findings on February 7-9, 2013 at MSOP administrative offices in St. Paul, MN. We applied current MSOP assessment criteria to determine the appropriateness of client placement in and movement between program phases. These criteria were:

- Goal Matrix for Phases I, II and III of the Program. The Matrix (MSOP Program Theory Manual, January 2013 draft, pp. 21-29) defines treatment goals in eleven areas that are the primary targets of treatment in the MSOP. These areas are: Group Behavior, Attitude to Change, Self-Monitoring, Thinking Errors, Pro-Social Problem Solving, Emotional Regulation, Interpersonal Skills, Sexuality, Cooperation with Rules and Supervision, Healthy Lifestyle, and Life Enrichment.

- Goal Matrix 5-Point Likert Rating Scale. A 5-point Likert rating scale (MSOP Clinician's Guide, January 2013 draft, pp. 13-14) defines broad criteria that are used to categorize client achievement on Matrix goals. Scale anchors are: (1) Deficient, (2) Needs Attention, (3) Satisfactory, (4) Enhanced, and (5) Proficient.

- Phase Progression. The Phase Progression document (MSOP Clinician's Guide, 2013 draft, pp. 15-16) sets criteria for client movement between phases based on client attainment of Matrix Goals using the 5-point rating scale and other behavioral benchmarks.

Although the MSOP began using the "Goal Matrix for Phases I, II and III of the Program" assessment scheme approximately three years ago, the Evaluation Team recognizes that it has not been fully implemented as intended and has been modified somewhat over time. Nevertheless, it has formed the foundation for how MSOP has assessed treatment progress and phase placement. Consequently, we used this scheme for determining whether treatment phase placement was consistent with MSOP Policies. For the criteria of "requesting group time," we used the therapists' ratings rather than percentages.

Findings and Recommendations

The following findings are based on the Evaluation Team's review of 50 clients' records, the five most recent MSOP Program Site Visit Reports, and current versions of the MSOP Program Theory Manual and MSOP Clinician's Guide.

1. Overall, the MSOP client records were complete and provided a substantial amount of clinical data on each client.

2. Overall, the Evaluation Team found that MSOP has followed their policies with respect to appropriate phase placement. The Evaluation Team found that 88% of clients were placed in the appropriate treatment phase based on MSOP policies. Table 2 shows the appropriateness of treatment phase placement by each of the three program phases. As shown in Table 2, all of the placements that the Evaluation Team determined to be inconsistent with MSOP policies were in Phase I.

Table 2. Treatment Phase Placement Consistent with MSOP Policies

Program Phase	Cases Reviewed	Phase Placement Consistent with MSOP Policies	
		Yes	No
I	20	14 (70%)	6 (30%)
II	]5	15 (100%)	0 (0%)
III	15	15 (100%)	0 (0%)
Total	50	44 (88%)	6 (12%)

3. The Evaluation Team believes that the MSOP thresholds to progress from Phase I to II and from II to III may be too high. With respect to progression from Phase I to II, in the current

MSOP Clinician's Guide, clients are required to achieve "Satisfactory" progress on all of the identified nine Matrix indices for two consecutive quarters in order to transition to the next phase. The Evaluation Team recommends that the program review whether it is necessary for clients to achieve a score of "Satisfactory" on all of the identified nine factors in order to meaningfully participate in the next phase of treatment. The Evaluation Team believes that the primary targets in Phase I should be treatment preparation, to include motivation, engagement, and appropriate group and unit behavior. With respect to progression from Phase II to III, the Evaluation Team believes that a rating of "Enhanced" may not be necessary on all of the identified nine Matrix indices to further treatment in Phase III.

4. The program should identify their criteria for movement from Phase Ill to Community Preparation Services.

5. The program should clearly indicate how long clients must demonstrate competency throughout Phase III privileges. in order to be recommended for Provisional Discharge. The Evaluation Team recognizes that new treatment issues may arise during initial exposure to supervised access to the community.

6. The Evaluation Team's review of records indicated that MSOP uses multiple theoretical orientations in Phase II and III, and that this appears to have interfered with phase progression.

7. The Evaluation Team's review of records supports the finding from previous Annual Evaluations that the program continues to experience challenges scoring clients reliably on the Matrix. The Evaluation Team supports the program's plan to conduct staff trainings to address this problem. It may be beneficial to establish behavioral anchors for the existing Likert scale, and to link these numerical scores with a narrative description of client behavior for each Matrix item, to guide scoring and promote consistency.

8. Quarterly reports should be organized to document barriers to phase progression and the status of documents relevant to phase progression (e.g., polygraph and penile plethysmsograph results, recent Behavioral Expectation Reports, and the status of relapse prevention and/or maintenance plans).

9. Some therapists' notes indicated that large group size and frequent staff changes interfered with client progress.

10. The current criteria for phase progression may need to be modified for certain populations of clients, including those persons with intellectual or developmental disabilities, severe and persistent mental illness, and significant cognitive impairment (e.g., dementia).

1]. The current criteria for Provisional Discharge for persons with intellectual or developmental disabilities, severe and persistent mental illness, and significant cognitive impairment (e.g., dementia) should reflect the reality that many of these individuals will be placed in environments that provide ongoing supervised care.

12. The Evaluation Team recommends instituting a quality assurance process in which clinical review is triggered when a client has not met the threshold for phase progression in a timely manner. This is consistent with the recommendation from the most recent Annual Evaluation.

13. Future reviews should be dependent on MSOP's effectiveness in moving clients through the treatment phases, including Provisional Discharge.

Respectfully Submitted,

James Haaven, M.A.

Christopher D. Kunkle, Psy.D.

Robert McGrath, M.A.

William Murphy, Ph.D.

Jill D. Stinson, Ph.D.

MSOP
MINNESOTA SEX OFFENDER PROGRAM
Minnesota Department of **Human Services**

March 21, 2013

Commissioner Lucinda Jesson
Minnesota Department of Human Services
Elmer L. Anderson Human Services Building
540 Cedar Street
St.Paul, MN 55101

RE: *Karsjens et al. v. Lucinda Jesson et al.*
Court File No. 11-cv-3659 (DWF/JJK)

Dear Commissioner Jesson:

In compliance with paragraph 6 of the Court's November 9, 2012, Order (Doc. No. 275), this letter provides the Minnesota Sex Offender Program's ("MSOP") comments to the attached MSOP Program Evaluation Team's February 13, 2013, Report on the Evaluation of Treatment Phase Progression ("Report"). Each of the Report's findings and recommendations will be addressed in turn.

1. *Overall, the MSOP client records were complete and provided a substantial amount of clinical data on each client.* (Report, p. 4.)

MSOP agrees with this finding.

2. *Overall, the Evaluation Team found that MSOP has followed their policies with respect to appropriate phase placement. The Evaluation Team found that 88% of clients were placed in the appropriate treatment phase based on MSOP policies… [A]ll of the placements that the Evaluation Team determined to be inconsistent with MSOP policies were in Phase I.* (Report, p. 4.)

MSOP agrees with the Evaluation Team's finding that MSOP consistently follows its policies with respect to its placement of Phase II and Phase III clients.

Additional information is needed for MSOP to fully respond to the Evaluation Team's finding that MSOP inconsistently follows its policies with respect to its placement some of its Phase I clients.

- MSOP will request that the Evaluation Team provide additional information regarding the basis of this finding.

- Upon receipt of this information, MSOP will re-examine its current system – i.e. quarterly reviews of each client's phase placement- to identify any systemic problems in its placement of Phase I clients.

- If systemic problems are uncovered, MSOP will actively work to rectify these problems.

3. *The Evaluation Team believes that the MSOP thresholds to progress from Phase I to II and from II to III may be too high. With respect to progression from Phase I to II, in the current MSOP Clinician's Guide, clients are required to achieve satisfactory" progress 011 all of the identified ni11e Matrix indices for two consecutive quarters in order to transition to the next phase. The Evaluation Team recommends that the program review whether it is necessary for clients to achieve a score of "satisfactory" on all of the identified nine factors in order to meaningfully participate in the next phase of treatme11t. The Evaluation Team believes that the primary targets in Phase I should be treatment preparation, to include motivation, engagement, and appropriate group and unit behavior. With respect to progression from Phase II to III, tile Evaluation Team believes that a rating of "Enhanced" may not be necessary on all of the identified Matrix indices to further treatment in Phase Ill.* (Report, pp. 4-5.)

MSOP acknowledges the Evaluation Team's recommendations. Based on the information currently available, MSOP believes that attention to more consistent application of the MSOP thresholds – as opposed to the modification of these thresholds- could promote and ensure a timelier phase progression for clients.

To address the opportunity for more consistent application, MSOP will take the following steps:

- Convene a committee of experienced clinical staff to draft additional descriptive behavioral anchors for each Matrix factor;

- Update its Clinician's Guide to reflect these behavioral anchors, thus providing clinical staff with ftn1her detailed guidance on the proper rating of the Matrix indices;

- Conduct supplemental staff trainings focused on the consistent application of the rating scale;

- Continue to require primary therapists to discuss each client's phase progression with a treatment team led by a clinical supervisor, and to solicit input from operations, health services, and rehabilitative services; and

- Monitor its clinical staffs application of the rating scale through periodic audits.

After completing the aforementioned tasks and no later than December 1, 2013, MSOP will reassess the "Satisfactory" and "Enhanced" thresholds to determine if additional modifications are necessary.

4. *The program should identify their criteria for movement from Phase III to Community Preparation Services.* (Report, p. 5.)

MSOP relies on statutory criteria when determining whether it will support a client's petition for transfer to Community Preparation Services (CPS).

CPS is a MSOP-operated building located outside MSOP-St. Peter's secure perimeter. Under Minnesota Statutes, transfer from a secure treatment facility to CPS constitutes a reduction in custody. Only the Supreme Court Appeal Panel (SCAP) may order reductions in custody. The Minnesota Legislature is responsible for identifying the criteria considered by the SCAP when ordering reductions in custody.

5. *The program should clearly indicate how long clients must demonstrate competency throughout Phase III privileges in order to be recommended for Provisional Discharge. The Evaluation Team recognizes that new treatment issues may arise during initial exposure to supervised access to the community.* (Report, p. 5.)

MSOP acknowledges the Evaluation Team's finding that it should provide additional guidance to its staff regarding the anticipated duration of each privilege phase. To address this finding, MSOP will do the following:

- Establish additional guidelines outlining the anticipated mm1mum duration of each privilege phase while accounting for individual abilities and treatment needs; and

- Provide clinical staff with supplemental training on new or modified guidelines.

MSOP agrees with the Evaluation Team's opinion that new treatment issues may arise during the exercise of clients' privileges. For this reason, MSOP will continue to base its support of a client's provisional discharge petition on numerous factors, including but not limited to a client's ability to meet statutory criteria and to demonstrate sustained, meaningful change while experiencing the unique challenges of Phase III privileges.

6. *The Evaluation Team's review of records indicated that MSOP uses multiple theoretical orientations in Phase II and III, and that this appears to have interfered with phase progression.* (Report, p. 5.)

MSOP agrees that, historically, MSOP-Moose Lake's clinical staff implemented program theory differently than MSOP-St. Peter's clinical staff. Since 2011, MSOP has been working to address this issue as follows:

- Comprehensively training clinical staff at both sites on the theoretical orientations reflected in MSOP's Theory Manual; and

- Actively monitoring clinical statJ's application of these theoretical orientations.

As reflected in the 2012 MSOP Annual Performance Report, the discrepancies between the sites have diminished as a result of MSOP's efforts. MSOP remains committed to ensuring that its staff adheres to MSOP's Theory Manual, now and in the future.

7. *The Evaluation Team's review of records supports lite finding from previous Annual Evaluations that the program continues to experience challenges scoring clients reliably 011 the Matrix. The Evaluation Team supports the program's plan to conduct staff trainings to address this problem. It may be beneficial to establish behavioral anchors for the existing Likert scale, am/ to link these numerical scores with a narrative description of client behavior for each Matrix item, to guide scoring and promote consistency.* (Report, p. 5.)

Please see MSOP's response to number three, above.

8. *Quarterly reports should be organized to document barriers to phase progression am/ the status of documents relevant to phase progression (e.g., polygraph and penile plethysmsograph remits, recent Behavioral Expectation Reports, and the status of relapse prevention and/or maintenance plans). (Report, p. 5.)*

MSOP agrees with the Evaluation Team's finding that its clients' quarterly reports should be reorganized to separately document barriers to phase progression, test results, prevention plans and maintenance plans.

- MSOP is currently working with the designers of its electronic program to redesign the quarterly report template to separately document the test results, treatment plans and Behavioral Expectation Reports.

9. *Some therapists' notes indicated that large group size and frequent staff changes interfered with client progress.* (Report, p. 5.)

MSOP agrees with the Evaluation Team's finding that large group size and frequent staff changes may have affected the phase progression of its MSOP-Moose Lake clients. MSOP-St. Peter adheres to MSOP's staffing pattern, and is not experiencing the disruptive effects of high turnover and/or an insuf1icient number of therapists.

MSOP is actively working to address its staffing concerns at MSOP-Moose Lake:

- MSOP is collaborating with DHS Human Resources and Minnesota Management & Budget (MMB) to address staffing concerns at MSOP-Moose Lake.

- The goal of this work is to fully and consistently staff MSOP-Moose Lake with trained and competent professionals as soon as possible.

- To date, MSOP has implemented flexible work hours; restructured employee classification so that MSOP clinicians are compensated comparably to DOC clinicians; provided outside supervision for licensure at no cost to the employee; made internships available to doctoral students to encourage future MSOP employment; and provided tuition reimbursement. MSOP is also working to create a system to recruit staff at national conferences, and is exploring the possibility of creating a loan repayment plan.

10. *The current criteria for phase progression may need to be modified for certain populations of clients, including those persons with intellectual and developmental disabilities, severe and persistent mental illness, and significant cognitive impairment (e.g., dementia).* (Report, p. 5.)

MSOP agrees with the Evaluation Team's recommendation that MSOP's phase progression criteria be modified for select MSOP clients.

- MSOP recognizes that clients with compromised executive functioning require interventions consistent with their responsivity needs.

- To meet these clients' needs, MSOP utilizes the Alternative treatment track.

- The Alternative treatment track is consistent with the overall program design and allows for individual modification based on ability, risk, and treatment needs.

- These individualized assessments require clinical supervisors to determine if the standardized phase progression is appropriate in light of the clients' disabilities, mental illnesses and/or impairments, if any. If it is determined through case consultation that the client has maximized the treatment benefits offered by his/her current phase, then the primary clinician may advance the client with the approval of his/her supervisor and the facility clinical director.

- Through these individualized assessments, clients in the Alternative program may be appropriately advanced through the treatment phases.

11. *The current criteria for Provisional Discharge for persons with intellectual or developmental disabilities, severe and persistent mental illness, and significant cognitive impairment (e.g., dementia) should reflect the reality that many of these individuals will be placed in environments that provide ongoing supervised care.* (Report, p. 5.)

MSOP acknowledges the accuracy of this finding, and is dedicated to seeking appropriate paths to reintegration for all of its clients. MSOP further recognizes that, due to their abilities and need, select clients may return to the community via an alternate path than Community Preparation Services.

- MSOP is currently reviewing when and how it will support the provisional discharge of clients with compromised executive functioning, including those clients experiencing intellectual or developmental disabilities, severe mental illness, and/or significant cognitive impairment.

- Upon completion of this review, MSOP will establish clearer criteria for when it will support provisional discharge for the aforementioned clients.

However, as mentioned above, the Minnesota Legislature – not MSOP – establishes statutory provisional discharge criteria, and the SCAP must base its orders for provisional discharge on such criteria.

12. *The Evaluation Team recommends instituting a quality assurance process in which clinical review is triggered when a client has not met the threshold for phase progression in a timely manner. This is consistent with the recommendation from the most recent Annual Evaluation.* (Report, p. 6.)

MSOP agrees with this recommendation, and has addressed this issue as follows:

- MSOP has proposed a protocol requiring two clinical supervisors to review the case of any client who has not progressed to the next phase within a set period of time.

- Under this proposed protocol, these supervisors would have the authority to progress a client if appropriate.

- If these clinical supervisors determine that phase progression is not appropriate at that time, then the client may request a review of his/her phase progression by a clinical director panel.

- MSOP will refine and implement this proposed protocol in the near future.

13. *Future reviews should be dependent on MSOP's effectiveness in moving clients through the treatment phases, including Provisional Discharge.* (Report, p. 6.)

MSOP agrees with this recommendation.

- Under current statute, independent evaluators review MSOP's clinical program on an annual basis.

- Historically, these independent evaluators have included client chart reviews in their rev1ew process. MSOP encourages these evaluators to continue this practice in the future.

- Although MSOP cannot require the SCAP to grant MSOP clients provisional discharge, MSOP will continue to make every effo11 to ensure timely phase progression within its treatment program.

* * * * *

MSOP sincerely appreciates the Evaluation Team's conscientious review of MSOP clients' phase progression. MSOP remains committed to providing its clients with comprehensive treatment in an effort to reduce the likelihood of sexual re-offense, and looks forward to continuing its efforts to improve its treatment program.

Please let me know if MSOP can provide any additional information as this matter moves forward.

Sincerely,

NANCY JOHNSTON
MSOP Executive Director

cc. The Honorable Donovan Frank (via chambers email only, with permission)
The Honorable Jeffrey Keyes (via chambers email only, with permission)
Steven Alpert, Assistant Attorney General (via email only)
Ricardo Figueroa, Assistant Attorney General (via email only)
Scott Ikeda, Assistant Attorney General (via email only)
Amy Kaldor Akbay, DHS Chief General Counsel (via email only)
Daniel E. Gustafson, counsel for *Karsjens* plaintiffs (via email only)
Karla M. Gluek, counsel for *Karsjens* plaintiffs (via email only)

Minnesota Sex Offender Program Site Visit Report

Site Visitors:	James 1-Iaaven, Private Consultant, Portland, Oregon Robert McGrath, McGrath Psychological Services, Middlebury, Vermont William Murphy, University of Tennessee, Memphis, Tennessee
Location:	Minnesota Sex Offender Program, Moose Lake, MN Minnesota Sex Offender Program, St. Peter, MN
Dates of Visits:	December 10-14, 2012
Date of Report:	December 27, 2012

Purpose and Overview

The Minnesota Sex Offender Program (MSOP) contracted with the consultants to review and evaluate its treatment program. The consultation was a component of MSOP's quality improvement program. This was a follow-up site visit from our previous program reviews in February 2006, October 2007, April2009, October 2010, and December 2011.

During the current review, we spent two days at the Moose Lake site, two days at the St. Peter site, and one half day reviewing and discussing our findings with the Executive Clinical Director and representatives at both sites via video conference from St. Peter.

Summary of Findings

Overall, the program has a strong foundation and is moving in several positive directions. The program continues to have a competent clinical and administrative leadership team. Staff report good collaborative working relationships between security and clinical staff at both sites. The leadership team recognizes and is working to address deficiencies in the program. In particular, slow movement through the program is an ongoing concern, and only one client has been provisionally discharged in recent years.

Since our last site visit, the program has updated documents that guide delivery of services in the program. The program has updated the "MSOP Program Theory Manual" (December 2012 draft), which details the overall rationale, theory, structure and empirical basis of the program. The program has prepared the "MSOP Clinician's Guide" (December 2012 draft), which provides clinicians with direction about how to deliver clinical services. Program administrators have scheduled to roll out these documents to program staff in trainings scheduled for January 2013.

The program has made considerable progress developing and implementing a series of treatment manuals for 65 psycho-educational modules. This is a significant accomplishment. The modules

are accessible to clinicians via an Internet web site. Of the 65 modules, 32 have been completed, 12 are scheduled for completion by January 2013, 13 by April2013, and the last 8 by July 2013.

The program is using the "Goal Matrix for Phases I, II and III" of the program. The Matrix focuses on dynamic risk factors that are linked to sexual reoffending. The Matrix is used to identify treatment needs, measure treatment progress, and benchmark criteria for moving between phases of the program. The program continues to experience challenges scoring clients reliably on the Matrix and has scheduled staff trainings to address this problem.

St. Peter continues to maintain clinical staffing levels as intended by program design. Although clinical staffing levels at Moose Lake had improved at the time of our last review in December 2011, clinical staffing levels at the site have since dropped, and this is a significant concern.

The percentage of clients in the MSOP who are enrolled in treatment remains at a relatively high level (84%), which compares favorably with other civil commitment programs for sex offenders.

Construction of the new Moose Lake complex is complete, with construction continuing in the main building. The new facility provides enhanced vocational areas and appropriately sized group rooms and other clinical space. Construction at the St. Peter site is underway to expand the number of program beds.

In terms of movement through the program, there has been a significant increase in the last year in the number of clients progressing from Phase I to Phase II of the program. However, the number of clients in Phase III of the program has remained relatively constant. In the Community Preparation Services (CPS) Program, the last phase of the program, the census has stayed about the same as at the time our last review. Whereas in the 3rct Quarter 2011 eight clients resided in the CPS Program, during the 3rd Quarter 2012, nine clients resided in the CPS Program.

Of the three clients who the program has recommended for provisional discharge, one has been provisionally discharged, one withdrew his petition for provisional discharge, and one was turned down for provisional discharge by the Supreme Court of Appeals.

As a result of a class action lawsuit against the program, the federal court has ordered formation of the Sex Offender Civil Commitment Advisory Task Force and charged it with examining and providing recommended legislative proposals on various areas of the Minnesota civil commitment system for sex offenders.

Procedures

We reviewed the following written materials:

- Updated draft "Theory Manual" (December 2012 draft)
- Draft "MSOP Clinician's Guide" (December 2012 draft)
- MSOP Quarterly Reports

During the site visit we engaged in the following activities:

- Met in individual and group meetings with senior management:
  - Nancy Johnson, Executive Director
  - Jannine Hebert, Executive Clinical Director
    Kevin Moser, Director at Moose Lake
  - Bonnie Wold, Director at St. Peter
  - Haley Fox, Clinical Director at St. Peter
  - Thomas Lundquist , Clinical Director at Moose Lake
    Elizabeth Barbo, Reintegration Director at St. Peter
- Toured facilities at both sites
- Met with the following staff groups without their supervisors present at both sites:
  - clinical supervisors (6 individual meetings)
  - clinicians (13 individual meetings)
  - rehabilitative services directors
    unit managers
  - security counselors
- Interviewed clients:
  - six clients in individual meetings at Moose Lake
  - several clients informally during unit visits and group treatment sessions at both sites
- Attended three treatment groups at Moose Lake and four treatment groups at St. Peter
- Attended two therapeutic unit community meetings, one at each site
- Reviewed the clinical records of six Moose Lake clients and four St. Peter clients
- Provided verbal feedback of our findings to Jannine Hebert, Executive Clinical Director
- Provided verbal feedback of our findings to a group of senior clinical and administrative directors and managers at both sites via video conference from St. Peter

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

Consultation Approach

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

Findings and Recommendations

The following sections of the report are organized around 12 best practice areas that are linked with effective sex offender treatment programs. We briefly define each key area, assess the program's functioning in that area and make recommendations for continued development.

1. Model of Change

The program has an explicit and empirically based model of change that describes how the program is intended to work.

Since our last site visit, the program has updated documents that guide delivery of treatment. These are:

- MSOP Program Theory Manual (December 2012 draft), which details the overall rationale, theory, structure, and empirical basis of the program
- MSOP Clinician's Guide (December 2012 draft), which provides clinicians with direction about how to deliver clinical services

Program administrators have scheduled to train staff on these documents beginning January 2013.

The program Theory Manual and Clinician's Guide describe the program theory as broadly cognitive-behavioral, structured, and skill based, which is an approach that is very consistent with best practices in the field. A strong emphasis is placed on client engagement and therapist style with a focus on positive approach goals, and these elements also have support in the research literature.

As we have noted in past reviews, some clinical practice in the program is at odds with what is set out in the program Theory Manual. First, a considerable portion of treatment time is spent in relatively unstructured process groups, which do not emphasize skill teaching, modeling, and practice. Second, Level II and III groups in the Conventional Program at St. Peter emphasize psychodynamic approaches, which place emphasis on psychological insight as opposed to skill building. We recommend a stronger emphasis on skill building and less emphasis on psychological insight as a treatment target.

2. Risk and Intensity of Services

The intensity of services is matched to the risk level and treatment needs of the clients.

Civil commitment programs focus on a high risk/need population and, therefore, should provide a relatively high level of treatment services.

The goal of the program is to provide about 8 hours of treatment to each client per week, and the program appears to be meeting this goal. This treatment dose is similar to that provided in other civil commitment programs.

Phase I treatment is designed to provide 4 hours of Core process groups per week and 3 hours of psycho-educational modules. Compared to recent years, this represents 2 hours less of Core groups per week and slightly more hours of psycho-educational groups per week in Phase I. We support this shift in emphasis. Phase II and III treatment, in general, is designed to provide 6 hours of Core process groups and at least 1.5 hours .of psycho-educational modules per week. At St. Peter, clients typically receive an additional two individual therapy sessions per month. Individual treatment sessions in the Conventional Program are typically about 50 minutes, and in the Alternative Program individual treatment session length is matched to the client's attention span. Individual therapy is not provided at Moose Lake for Phase II clients.

Since our last visit, the program has begun conducting one-hour weekly therapeutic community meetings on each living unit. It has been challenging to conduct these meetings on the large 68 and 98 bed units at Moose Lake. The therapeutic community meetings in the Alternative Program and the smaller units appear to be working as intended.

3. Treatment Targets

The program assesses clients' changeable problems that are closely linked to sexual and other offending behavior and targets them in treatment. These are commonly called "dynamic risk factors."

The program uses the "Goal Matrix for Phases I, II and III" as its primary dynamic risk measure. The Matrix is used to identify treatment needs, measure treatment progress, and benchmark criteria for moving clients between phases of the program. Having a structured system for measuring progress is consistent with best practices.

Since our last site visit, the program has printed the Matrix treatment goals on pocket size cards and provided them to clients and staff. We support this transparency of program treatment goals among clients and staff throughout the facilities.

Clinical directors are scheduled to provide further training to clinical therapists in January 2013 on scoring the Matrix. This is important because clinical staff and clients commonly indicated that some confusion exists about the definitions of and how to score some items on the Matrix.

We recommend that security, education, and recreational staff receive training on the Matrix to maximize their role in addressing clients' specific treatment goals. Further, we recommend that the program develop a formal system for regular structured chart audit to assess Matrix scoring accuracy. The program should survey staff on the scoring criteria and areas that lead to difficulties in scoring. Refresher training should be offered on at least a yearly basis. We

also recommend that the program develop mock cases for clinical staff to score to test scoring accuracy.

4. Responsivity

The program delivers services in a fashion to which clients can most successfully respond.

This best practice concerns the "responsivity" principle and focuses on how services are delivered. Programs should consider responsivity issues such as clients' motivation, intelligence, psychopathy, mental illness, and cultural issues. Therapist style is an additional important responsivity issue. Greater treatment impact is found when the therapist is firm, fair, direct, and empathetic and shows an overall concern for the client's well being.

As a broad indicator of program responsivity, the percentage of clients enrolled in treatment remains relatively high (84%), and this compares favorably with other civil commitment programs for sex offenders.

Since our last program review, the program provided all clinical staff one-week trainings on building therapeutic alliance and motivational approaches in sex offender treatment. As during past reviews, clients generally reported relatively good working relationships with primary and group therapists.

Frequent staff turnover and program growth, primarily at Moose Lake, has led to less experienced staff and frequent changes in clients' primary and group therapists. These problems have impacted therapeutic engagement negatively. As a result of low clinical staffing levels, group size is larger than ideal, which does not allow sufficient time to cover therapeutic assignments in a timely manner.

Additionally, low clinical staffing levels at Moose Lake has resulted in Phase II clients not receiving individual therapy as they do at St. Peter, which results in the Phase II programs at the two sites being non-equivalent.

Since our last review, the program has dispersed non-program participants across program units rather than congregating them on a single unit. Staff consistently report that this approach has resulted in a reduction of behavior problems and increased non-participants' enrollment in treatment. The program has instituted a policy whereby clients have input with respect to roommate assignments.

The new psycho-education modules are written at a comprehension level appropriate for most clients in the Conventional Program. Staff recognized that these modules require some adaptations for clients in the Alternative Program and have initiated a plan to make adaptations.

The program has developed Behavioral Management Units (Omega, Omega 2 and Omega 3) and appears to be being using them effectively. Staff monitor client length of stay closely, and timely return of clients to their parent units appears to be taking place.

5. Program Sequence

The sequence and spacing of services is logical and responsive to clients' treatment needs and learning styles.

We continue to believe that the overall program sequence is logical and appears to be responsive to clients' treatment needs and learning styles. The program sequence is broadly set out in the Goal Matrix for Phases I, II and III which details client goals for each phase of the program.

Since the last visit, the Executive Clinical Director has completed the Program Theory Manual. The Program Theory Manual more clearly articulates which treatment goals for each matrix area are to be completed within each phase. In addition, the manual specifies specific psycho-educational modules for each phase and links these to specific dynamic risk factors. Such specification is consistent with best practices.

In the last year, the Executive Clinical Director also has developed a Clinician's Guide that specifies criteria, based on Goal Matrix goals and scores, to move between Phases. These appear to be sequenced logically.

As shown in Table 1, there has been a significant increase in the last year in the number of clients progressing from Phase I to Phase II of the program, but the number of clients in Phase III and Community Preparation Services (CPS) has remained relatively constant. One client was provisionally released from the MSOP during the last year.

Table 1. Participant by Program Phases

Program Phase	3rd Quarter 2011	3rd Quarter 2012
Phase I	378	350
Phase II	106	182
Phase III	24	22
CPS	8	9

Of the three clients who the program has recommended for provisional discharge, one client has been provisionally discharged, one withdrew his petition for provisional discharge, and one was turned down for provisional discharge by the Supreme Court of Appeals.

The Goal Matrix may address some of the factors contributing to the apparent slow movement through the program. However, as noted in our last review, we suggested that the program continue to examine this issue. In particular, we have some concerns that staff may have overly high expectations for movement between Phases II and III of the program. Other possible impediments to program movement include the degree of treatment emphasis placed on therapeutic processing versus skill building and practice, and the amount of credit given for past programming. Clients consistently expressed concerns that slow movement through the program, including the fact that only one individual has been released in recent years, was demoralizing, increased hopelessness, and negatively impacted motivation and engagement.

6. Effective Methods

The program employs methods that have been consistently demonstrated to be effective with clients.

Programs should be structured and skills oriented and utilize techniques such as cognitive restructuring, training in self-monitoring, modeling, role-play, graduated practice with feedback, and contingency management. In general, more effective correctional programs allocate about half of treatment time to skill building interventions focused primarily on clients' criminogenic needs. Overall, programs for offenders that are manualized are more effective than those that are not.

The program has made considerable progress developing and implementing a series of structured treatment manuals for 65 psycho-educational modules. This is a significant accomplishment. Of the 65 modules, 32 have been completed, 12 are scheduled for completion by January 2013, 13 are to be completed by April2013, and the last 8 by July 2013.

Overall, the group psycho-educational modules place a greater emphasis on skill development than do the core process groups. However, the structure of the psycho-educational groups is that when homework is assigned, it is to be reviewed in the core groups. Therapists and clients stated consistently that this did not happen. Therapists reported that there was insufficient time to review the homework given other activities relegated to core group such as reviewing Behavioral Expectation Reports and Treatment Memos. Groups have also increased in size at Moose Lake since our last review. Additionally, some therapists have the perception that it is solely the clients' responsibility to request time for homework. Often, the therapist in the core group did not know what homework clients were assigned in their psycho-educational modules and did not know the content of certain modules. For homework to be optimally effective, it needs to be reviewed in a timely fashion.

As we have noted earlier in the Model of Change section of this report, Level II and III groups in the Conventional Program at St. Peter emphasize psychodynamic approaches, which places an emphasis on psychological insight as opposed to skill building. We recommend a stronger emphasis on skill building throughout all aspects of the program and less emphasis on psychological insight as a treatment target.

The evaluation team continues to be impressed with the services offered by recreational therapy, education, and vocational services. At Moose Lake, recreational services are offered seven days a week, including evenings, and a St. Peter every day except Sunday. Vocational programs are better developed at Moose Lake and work is ongoing to increase vocational services at St. Peter. These services are an important part of therapeutic programming and assist clients in generalizing skills that they learn in other aspects of the program. Rehabilitation services address a number of social and life skills groups that focus on dynamic risk factors listed on the Matrix. These should specifically be integrated into each client's Individual Treatment Plan.

In the past, individual therapy had been offered on some of the special units at Moose Lake. Both therapist and security staff reported that the availability of individual therapy had a positive impact and decreased disruptive behavior. However, due to staff shortages, individual therapy could not be continued. We recommend restarting these services when staffing levels increase.

7. Continuity of Care

Progress that clients make in the institution is reinforced and strengthened by treatment and supervision in the community.

The program has components in place to gradually "step-down" clients to the community through programming in Phase III and CPS. The number of clients in Phase III and CPS are about the same at during our last site visit. Of the three clients who the program has recommended for provisional discharge, one has been provisionally discharged.

The program continues to provide community outings as part of the "step-down" process. We support this policy and its focus on ensuring that these outings are linked to treatment goals. During the last year, the recreational therapy department has developed programs to involve CPS clients in appropriate community service activities to "give back" to the community, and we support this initiative.

We continue to note the need for discharge options for clients in the Alternative Program who have reached maximum program. Many clients in the Alternative Program will always need 2417 supervision, but their risk could be managed in a less restrictive community settings. The level of risk reduction needed for Alternative Program clients to live safely in supported living environments in the community is different from clients in the Conventional Program, who at some point may live independently.

As we have noted in past reports, the program has in place appropriate components for helping clients prepare for discharge and reintegrate in the community, however, only one has been discharged in recent years. Slow movement through the program and the multiple required legislative steps for discharge in Minnesota hampers program effectiveness. The lack of clients "getting out" can be demoralizing to clients and staff, and in the long run may increase security concerns.

8. Program Monitoring and Evaluation

The program monitors its operation continuously to ensure that services are delivered as intended, the quality of services are improved, and the effects of services are evaluated.

The program continues to have processes in place for monitoring the ongoing functioning of the program. These include daily Morning Report meetings involving senior staff from all departments, unit meetings, and shift meetings. Quality assurance procedures are in place to monitor a variety of activities including record keeping and debriefing critical incidents.

Quarterly reports detail action plans to address program goals and progress attained reaching goals. The present review is a review of the program by external experts, and this process is considered a best practice in the field.

The Goal Matrix is an important component of measuring client progress. We stress that all staff should receive training on the Goal Matrix.

Since our last visit the program has introduced a risk management panel composed of the senior clinical leadership. This committee has reviewed treatment team recommendations for movement from Phase II to Phase III. Many analogous systems have similar risk management committees to review significant risk related decisions. We suggest, however, that the program consider whether this review committee would best be reserved for movement from Phase III to CPS. The evaluation team also recommends instituting a quality assurance process in which clinical review is triggered when a client is not making progress or progressing through Phases in a timely manner.

9. Staff Training, Supervision and Support

Staffing levels are adequate and staff are appropriately selected, trained, and supervised.

As noted in previous reviews, staff across disciplines appear to be dedicated and committed to the program. Executive Clinical Director Jannine Hebert has continued to provide needed program stability after several years of multiple changes in clinical leadership. Her work this year on the psycho-educational modules and continued implementation of the Goal Matrix continues to refine and improve the program.

St. Peter continues to maintain clinical staffing levels as intended by program design. Although clinical staffing levels at Moose Lake had improved at the time of our last review in December 2011, clinical staffing levels at the site have since dropped, and this is a significant concern. At the time of the present site visit, of 54 clinical positions at Moose Lake, 16 positions were vacant. Of 11 clinical supervisor positions, two positions were vacant. Despite these staff vacancies, the program appears to continue to provide the expected number of treatment hours, but at the expense of increased group size.

We are concerned, however, about the decrease of clinical staff on the Behavioral Management Units as well as Mental Health Unit. Nevertheless, we note that the treatment psychologist and unit directors on those units appear to be maintaining therapeutic environments under challenging circumstances.

The program has taken a number of steps to improve staff retention and morale. The program provides new staff free outside supervision to meet licensure requirements. The program has increased pay and provided flexible work hours. The program facilitates a weekly group for new therapists to orient them to the program. The rural location of Moose Lake will likely continue to make staff recruitment and retention difficult.

In terms of psychiatric staffing, across both sites, the program has a full-time psychiatric nurse practitioner and 12 hours of psychiatrist time per week. We concur with program leadership that the level of psychiatric services appears to be low for a program of this size.

The evaluators continue to be very impressed with the Unit Directors at Moose Lake and St. Peter. In our experience, this is clearly a strong and committed group who work to balance the therapeutic and security aspects of the program. At Moose Lake, given frequent clinical staff and clinical supervisor turnover, Unit Directors provide stability at the line management level. However, the Unit Director to client ratio has been reduced in recent years and the units are larger, which makes it more difficult for them to have a presence on the units. This is especially true at Moose Lake. The program should evaluate whether the current staffing pattern of Unit Directors is appropriate.

Staff interviews indicate good working relationships exist between Unit Directors and Clinical Directors in all programs and generally among security, recreational, and clinical staff in most programs. The notable exception was that multiple staff expressed concerns that clinical staff in the Conventional Program at St. Peter tended to exclude other disciplines with respect to information sharing and collaborative decision-making.

The program continues to provide staff ongoing training to upgrade their skills. In the last year, recognized experts provided training on developing therapeutic relationships and another on healthy sexuality. Program administrators reported that all clinical and rehabilitative services staff attended the recent Minnesota ATSA (Association for the Treatment of Sexual Abusers) yearly meeting. Approximately 20 staff attended the ATSA national conference. Providing continuing education training to staff is a strength of the program.

In most instances, the program continues to provide regular clinical supervision to clinicians; about one hour or more of individual supervision a week for newer staff and about one hour a month for senior staff.

10. Service Documentation

Staff document services in an appropriate, thorough. and timely manner.

We conducted more limited chart reviews this visit than in previous years, as we are scheduled to conduct more detailed chart reviews at a later date. We note that since the new electronic record has been implemented, notes have become more limited and not as directly tied to Matrix goals. The program recognizes and is addressing this issue. On the other hand, individual treatment plans continue to be appropriately tied to Matrix goals.

11. Facility and Treatment Environment

The facility and treatment environment is safe, secure, and therapeutic.

The correctional design of the new Moose Lake housing units continue to make it difficult to operate a therapeutic milieu. As we noted last year, staff softened the environment by using carpeting, painting, and other features to make the units more appealing than typical prisons. The program has begun holding therapeutic community meetings on these units in an attempt to create and encourage a more positive environment. It will take some time to see if these efforts are effective.

Other positive changes include removing a fence around the outdoor space of the Phase II housing units, and this provides a more open environment with less of a correctional feel. A major complaint of clients over the last few years, especially at Moose Lake, has been the introduction of a more restrictive movement policy. The program introduced an ankle monitoring system (AMS) for Phase II clients and is in the process of introducing the same system for Phase I clients. As a result, fewer restrictions on movement now exist. Although some clients resent the AMS, most report the result of more open movement as a positive program change. Clients are also being allowed to choose roommates with staff approval, which the clients also see as positive.

St. Peter continues to have smaller units for all clients in the Alternative Program and Phase II Conventional Program. The smaller size and involvement of more advanced clients lend to more therapeutic client interactions among clinical and security staff. St. Peter is in the process of remodeling two more units, which will increase their bed capacity.

As noted in our previous reports, the ratio of security counselors to clients decreased markedly a few years ago, and this makes it difficult for security staff to be as involved in the therapeutic aspects of the program. We still believe that this makes it more difficult for security staff to know clients and to be able to respond to the security and therapeutic goals of the program. Additional staffing exists for specialized units (young adult, mental health, and behavior), which have greater needs for supervision.

The new Moose Lake complex is complete and provides much needed programming space. It also provides more dining, vocational, recreational, and educational space. These spaces are well designed and address many of the needs at Moose Lake. There is a therapeutic environment committee, which has client involvement, and they are assisting in choosing wall decorations in the new areas.

In the Alternative Program, a high level of engagement is evident between the security counselors and therapists. In particular, Alternative Program security counselors expressed a desire to have a more active role in the therapeutic program.

In recent years, the program had increased client restrictions and security staff took on a more exclusive security role. As we noted in our last report, Kevin Mosher, Director of Moose Lake, took a lead role in promoting an increased therapeutic milieu without

compromising security needs at the facility (e.g., removal of a fence and increased client movement).

Although infrequent, some clients have committed serious assaults on staff and other clients. To date, the program has had only limited success in gaining cooperation from local prosecutors in prosecuting serious felonies. To protect staff and clients, we support criminal prosecution of serious criminal offenses within the facility and believe that this is an area that needs attention.

12. Administrative Structure and Program Organization

The administrative structure and program organization supports the healthy functioning of the program. Staff communicate effectively in order to ensure that clients' services are coordinated.

The program has a strong administrative structure and processes in place to ensure ongoing staff communication. There is stability in clinical leadership. Although some senior leadership staff retired in the past year, the individuals who filled these positions have proven leadership skills and are very knowledgeable about the program. The program continues to staff clients at least quarterly and conduct comprehensive yearly reviews.

MSOP
MINNESOTA SEX OFFENDER PROGRAM
Minnesota Department of Human Services

April 5, 2013

The Honorable Jeffrey J. Keyes
United States District Court
646 Warren E. Burger Federal Courthouse
316 N. Robe1t Street
St.Paul, MN 55101

RE: *Karsjens et al. v. Lucinda Jesson et al.*
Court File No. 11-cv-3659 (DWF/JJK)

Dear Magistrate Judge Keyes:

Thank you for the opportunity to respond to the December 27, 2012, Minnesota Sex Offender Program Site Visit Report ("Report") authored by Messers. James Haven and Robert McGrath and Dr. William Murphy ("the Evaluation Team"). The following constitutes the- Minnesota Sex Offender Program's ("MSOP") response to the specific items identified in your February 27, 2013, memorandum.

1. *Skill Building ami MSOP's Treatment Program.*

The Minnesota Sex Offender Program ("MSOP") agrees with the Evaluation Team's suggestion that skill building is a key component of a comprehensive and effective sex offender treatment program.

Prior to receiving the Report, MSOP began providing various skill building opportunities to its clients.

- MSOP provides skill building opportunities to clients in all treatment phases and in a range of settings, including: therapeutic rehabilitation, education, vocational, clinical, and unit settings. Staff overseeing the aforementioned settings provide input to treatment providers regarding the clients' ability to demonstrate appropriate social skills and meaningful change.

- MSOP also provided Phase III clients with additional skill building opportunities through Phase III privileges. These privileges allow clients the opportunity to demonstrate and further practice the skills they acquired during earlier phases of treatment in real life settings.

Since receiving the Report, MSOP has actively sought to incorporate additional skill building opportunities into MSOP's treatment programming. In January 2013, MSOP clinical leadership met to discuss how best to incorporate a skill building emphasis particularly in treatment groups. As a result of these discussions, MSOP has taken or will take the following steps to increase the number of skill building opportunities offered to its clients:

- MSOP updated its psychoeducational programming to increase the amount of skill building opportunities provided to clients.

- To better monitor the amount of skill building opportunities provided to clients, clinical directors and clinical supervisors will enhance and formalize their supervision of groups.

- Beginning in the second quarter of 2013, MSOP-Moose Lake rehabilitation staff will instruct certain psychoeducational modules on unique skill acquisition.

- In the coming months, MSOP will provide additional training to its clinical staff to ensure skill building development and practice are further incorporated into treatment.

2. *Homework Review*

MSOP agrees with the Evaluation Team's finding that some therapists at MSOP-Moose Lake struggle to find time to review clients' homework assignments.

- MSOP is committed to ensuring that its clients receive appropriate and timely feedback on their homework assignments.

- In the near future, MSOP clinical leadership will thoroughly investigate the nature and extent of this issue with MSOP's primary therapists.

- Based on MSOP's preliminary investigation, it appears that this issue is largely attributable to (I) insufficient training, and (2) staffing issues.

    - MSOP will work with its clinical staff on how to better utilize group time, thus equipping them with the skills and time necessary to provide meaningful and timely feedback to clients on their homework assignments.

    - Historically, clinical staff reviewed clients' homework assignments in group sessions and/or individual therapy sessions. Staffing shortages at MSOP-Moose Lake currently limit clinical staffs ability to conduct individual therapy sessions. As further discussed below, MSOP is actively working to address the staffing shortages at MSOP-Moose Lake.

3. *Individual Therapy at Moose Lake*

MSOP agrees with the Evaluation Team's finding that MSOP discontinued universal individual therapy sessions at MSOP-Moose Lake facility due to staffing shortages. MSOP will reinstate individual therapy sessions at MSOP-Moose Lake when staffing shortages are mitigated.

- The staffing shortages at MSOP-Moose Lake are not attributable to funding shortfalls: according to staff exit interviews, most staff resign from MSOP-Moose Lake due to Moose Lake's rural location.

- As indicated in the Report, MSOP has provided its clinics! staff with a number of incentives, including but not limited to providing free outside supervision to meet licensure requirements, and conducting a reclassification of individuals working as primary therapists that resulted in more competitive compensation. (Report, p. 10). In its on-going effort to attract and retain qualified staff: MSOP has also offered internships to doctoral students, provided tuition reimbursements, and implemented an aggressive strategy to be present national conferences attended by potential staff.

- MSOP is continuing to work with the Minnesota Department of Human Services (DHS) and Minnesota Management & Budget ("MMB") to develop additional ways to attract and retain qualified staff. Specifically, MSOP is currently exploring the possibility of providing a pay differential to professionals working in rural areas of Minnesota, creating a support position to assist therapists, continuing its recruitment efforts at national conferences, and creating a loan repayment plan.

4. *Reliable Matrix Scoring*

MSOP agrees with the Evaluation Team's finding that MSOP's clinical staff require regular training on how to consistently and accurately score the Matrix factors. MSOP is actively working to address this issue.

- In January 2013, MSOP conducted an extensive training with all clinical staff that was dedicated to Matrix factors, treatment progression markers, and therapeutic skills.

- In May 2013, MSOP will provide supplemental, detailed training on the Matrix factors to *all* staff.

- MSOP clinical leadership will continue to discuss the Matrix factors and their scoring during case consultations and treatment team meetings.

- MSOP is developing a new staff position dedicated to conducting internal audits to better ensure the consistent application and scoring of the Matrix factors across all of MSOP.

5. *Staffing Levels at MSOP-Moose Lake*

Please see MSOP's response to number three, above.

6. *Number and Role of Security Counselors*

MSOP agrees with the Evaluation Team's finding that MSOP has reduced the numbers of security counselors at MSOP-Moose Lake. MSOP is committed to providing its clients with a therapeutic atmosphere, and it recognizes that its staff, including but not limited to security counselors, play an important role in achieving this goal.

- Security counselors are currently included in unit and community meetings.

- MSOP will provide all security counselors with supplemental training on MSOP's treatment program in May 2013. This training will be in addition to the quarterly unit trainings currently provided to both clinical staff and security counselors.

- MSOP is currently considering the creation of an additional paraprofessional position at MSOP-Moose Lake dedicated to assisting primary therapists, facilitating psychoeducational groups, and interacting in a therapeutic manner with clients residing in the larger units at MSOP-Moose Lake. As conceptualized, this position would further enhance MSOP-Moose Lake's therapeutic environment.

MSOP acknowledges the Evaluation Team's finding that the Alternative Program's security counselors are interested in playing a more active role in the creation of a therapeutic atmosphere for their clients.

- MSOP-St. Peter's leadership team and its clinical supervisors have discussed this finding with the Alternative Program's security counselors. Based on these discussions, MSOP believes that this finding reflects the feelings of a single team member.

- MSOP is dedicated to ensuring that all staff members are actively involved in providing its clients with a therapeutic environment. Operations and clinical staff are encouraged to share their insights regarding specific clients as well as the program as a whole. MSOP works to achieve this goal during its frequent trainings, meetings and case discussions, which are attended by both operations and clinical staff.

7. *Prosecution of Crimes*

MSOP agrees with the Evaluation Team's finding that the relatively limited prosecution of crimes committed at MSOP-Moose Lake and MSOP-St. Peter must be addressed.

- DI-IS' Office of Special Investigations (OSI) is responsible for investigating any and all incidents of alleged criminal behavior involving MSOP clients. MSOP believes that OSI performs this work in a conscientious manner, and functions as a valuable resource to MSOP, local law enforcement, and the prosecuting attorneys.

- Between 2008 and 2012, OSI referred 382 cases for prosecution. Although OSI regularly provides information to local law enforcement and prosecuting attorneys to assist them in the prosecution of the referred cases, neither OSI nor MSOP has the at1thority to require said prosecution.

- Between 2008 and 2012, 117 – or approximately 30 percent – of the cases referred by OSI reached final disposition.

- In the future, OSI will continue to investigate each and every· alleged criminal act involving MSOP clients, and refer cases for prosecution as appropriate.

- In the coming months, MSOP will reach out to local law enforcement to determine if and how it may offer additional assistance in this area.

8. *Rehabilitation Services*

MSOP agrees with the Evaluation Team's recommendation to specifically integrate a client's rehabilitation services into his/her Individual Treatment Plan.

- MSOP will continue to require its rehabilitation staff to participate in trainings focused on the full integration of clients' rehabilitation services into their respective treatment plans.

- Both MSOP-Moose Lake and MSOP-St. Peter are in the process of hiring rehabilitation supervisors. One of the responsibilities of these rehabilitation supervisors will be to more fully integrate and formalize the use of rehabilitation services in each client's Individual Treatment Plan.

- Within the next three months, MSOP-Moose Lake and MSOP-$t. Peter's clinical directors will provide additional training to all rehabilitation staff on the Matrix factors.

9. *Discharge Options for Clients in the Alternative Program*

MSOP agrees with the Evaluation Team's recommendation that MSOP should develop additional, appropriate discharge options for clients in the Alternative Program. MSOP further agrees with the Evaluation Team's finding that while some of these clients may permanently require 24 hour supervision, the risk posed by some of these clients may be competently managed in an alternative setting in the future.

- On January 31, 2013, MSOP and State Operated Services issued a Request for Information (''RFI"), seeking information from other organizations willing and able to provide appropriate treatment and supervision for MSOP's existing and future clients, including but not limited to those participating in MSOP's Alternative Program. The purpose of this RFI was to assess Minnesota's current provider capacity; gauge interest among the existing providers; avoid creating duplicative programs; facilitate investment in existing programs to expand current capacity; and identify resources that are readily accessible.

- Twenty-two organizations responded to the above-mentioned RFI. MSOP is currently analyzing these responses, and soliciting additional clarification and information from select providers.

10. *Discharge Steps*

MSOP agrees with the Evaluation Team's finding that the statutorily mandated process for provisional discharge and discharge has slowed the release of MSOP clients.

- MSOP is providing technical assistance to legislative members as they explore how best to amend the existing statutory language relating to reductions in custody.

- As mentioned above, and consistent with the December 2012 recommendations of the Sex Offender Civil Commitment Task Force, MSOP is exploring alternatives to its secure treatment facilities.

- MSOP remains dedicated to supporting the provisional discharge and discharge of its clients if and when they meet statutory criteria for reductions in custody. .

11. *Risk Management Panel*

MSOP agrees with the Evaluation Team's observation that MSOP has formed a risk review panel consisting of senior clinical leadership. As mentioned in the Report, this panel is responsible for reviewing recommendations from the treatment team that a client progress from Phase II to Phase III. This panel does not currently review clients' placement in Community Preparation Services (CPS).

- Under Minnesota Statutes, clients must petition the Special Review Board and the judicial appeal panel for CPS placement. Clients in all phases of treatment frequently petition for this placement. In 2012, the judicial appeal panel heard 87 petitions for provisional discharge, discharge and/or CPS placement.

- MSOP clinical staff regularly reviews each Phase III client's treatment records to determine if the client is ready for CPS placement. These periodic reviews are in addition to the clients' quarterly reviews. If MSOP identifies a client who is ready for CPS placement, MSOP will encourage that client to petition for CPS placement.

- As recommended by the Evaluation Team, MSOP will reevaluate whether this panel should focus its efforts on clients seeking CPS placement instead of – or in addition to – clients progressing from Phase II to Phase III.

12. *Quality Assurance Process/Review*

MSOP agrees with the Evaluation Team's finding that MSOP should have a quality assurance process whereby clinicians review the treatment records of clients who are not progressing through the treatment phases in a timely manner.

- Currently, each client's primary therapist conducts an annual review of the client's treatment to assess his/her treatment progress, identify any treatment barriers, and determine if phase

progression is appropriate. These annual reviews are reviewed by the primary therapist's clinical supervisor.

- MSOP is currently developing a new policy to enhance oversight of clients' treatment progress and phase progression. Under this policy, when a client has remained in any given phase for 24 months or longer, two clinical supervisors, along with the client's primary therapist, will conduct the above-mentioned annual review. Working in a collaborative manner, these treatment professionals will work to identify any treatment barriers, and explore how these barriers may be addressed.

- MSOP offers Applications groups for clients in all phases of treatment. These groups are specifically designed to target specific treatment interfering behaviors or attitudes. In this open-ended group, clients spend extra time exploring and addressing any attitudes, behaviors or issues that may be interfering with their treatment progress.

13. *St. Peter Clinical Staff*

MSOP acknowledges the Evaluation Team's finding that clinical staff at MSOP-St. Peter excludes other disciplines at times.

- This observation surprised MSOP leadership, and prompted a thorough evaluation of this issue. Based on this evaluation, MSOP is confident that this finding reflects a concern of a single staff member. Site leadership will personally meet with this staff member in the near future to better understand and address his concerns.

- During the aforementioned evaluation, operations staff expressed satisfaction with their working relationship with clinical staff, and stated that they believed clinical staff valued their role and input.

- MSOP sincerely values the insight and input of each member of its staff. MSOP will continue to monitor this issue, and will promptly address any concerns regarding how information is shared amongst staff and emphasize the use of collaborative decision-making at its facilities.

14. *Electronic Recordkeeping*

MSOP agrees with the Evaluation Team's finding that the electronic records created by MSOP staff must be comprehensive and tied to Matrix goals.

- MSOP will provide additional training on accurate and comprehensive electronic recordkeeping to its clinical staff. Clinical staff at MSOP-Moose Lake will receive this training this quarter; and MSOP-St. Peter clinical staff will receive this training next quarter.

* * * * *

MSOP sincerely appreciates the Evaluation Team's thorough review of MSOP's strengths and weaknesses. MSOP is committed to addressing its shortcomings, as identified by the Evaluation Team, to ensure that its clients receive comprehensive and effective treatment, now and in the future.

Please let me know if MSOP can provide any additional information.

NANCY JOHNSTON
MSOP Executive Director

cc. The Honorable Donovan Frank (via chambers email only, with permission)
Lucinda Jesson, Commissioner of Human Services (via email only)
Steven Alpert, Assistant Attorney General (via email only)
Ricardo Figueroa, Assistant Attorney General (via email only)
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