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Barriers to Release and Potential Solutions

WHY THE MINNESOTA SEX OFFENDER PROGRAM DOES NOT WORK AND WHAT OFFICIALS CAN DO ABOUT IT.

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2/7/2021

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February 7, 2021

Notice: We attempted to identify what department is more likely to have jurisdiction over a particular *Barrier to Release*. We hope this helps you hone in on issues you may have more impact on. The following key shows how we separated them.

DHS: Department of Human Services (Commissioner, Jodi Harpstead)
HHSFD: Health and Human Services Finance Division (Representative, Tina Liebling)
MSOP: Minnesota Sex Offender Program (Clinical Director, Peter Puffer and Facility Director, Kevin Moser)

(HHSFD)
Barrier to Release No. 1: There is far too much money invested into the program.

MSOP cost taxpayers $111 million in 2020. MSOP Executive Director, Nancy Johnston, made $157,323.92 in 2020. This is excessive for a program that has produced almost 0 results. Clinical Director, Jannine Hebert, got a total of $26 an hour in raises between 2008 and 2017 even though no one had been "treated" and released in that period of time. By 2019, Hebert was making $70.68 an hour. The highest paid person at the MSOP currently is Mustafa Kendi, a psychiatrist who makes $141.77 an hour.

Potential Solution to Barrier No. 1: Defund MSOP and reallocate the money to victim advocacy and programs in prison. More recently, Minnesota has implemented lengthier prison terms where convicted sex offenders will have ample time to complete treatment at a much lower cost than civil commitment.

Judge R. A. Randall states:

> ...Our resources, the taxpayers' money, would be better spent on real programming in prison and programming in the community... Where would all the money come from to ramp up what present programs there are in prison for sex offenders? Those funds dollars would come from the budget for MSOP... Do the math: 698 at $120,000 a year equals $83,760,000; 698 at $140,000 a year equals $97,720,000. That is the present[1] budget to warehouse people at MSOP.[2]

[1] This was written in 2014. Using the same math, the number is $107,583,750 as of February 1, 2021

[2] *In the Matter of the Civil Commitment of: Eric John Eischens*, COURT OF APPEALS OF MINNESOTA, 2014 Minn. App. Unpub. LEXIS 622, A14-0013, June 23, 2014, Filed, Dissent by: Randall, Judge

(MSOP)
Barrier to Release No. 2: At MSOP, clients are not assessed according to a current presentation of mental illness. They are assessed according to pre-commitment behaviors.

For all paraphilia diagnosis, "Current" means the last 6 months.[3] [4] Psychologists are responsible for updating the client's mental health diagnosis on an annual basis. This is usually not done directly by the psychologist, but by someone working "underneath" a psychologist during a "Mental Health Assessment." During the assessment, the client is usually asked to speak about his criminal record no matter how old it is. The client is never encouraged to speak about his current mental state or behaviors and does not know that he should. Therefore, a client finds himself at the Special Review Board attempting to mitigate his pre-commitment behaviors year after year. The result is almost always the same: continued confinement.

Potential Solution to Barrier No. 2: employ a onetime independent evaluation for the entire MSOP population to determine placement based on federal statute, 18 USC 4247. The evaluation must assess men according to observable objective and current behaviors – and not their criminal records. Create a Judicial Bypass process pursuant to 253D to allow a licensed doctor to outright terminate the commitment without court approval.

Independent evaluations could be procured by a firm not affiliated with MSOP and would reconvene on a regular basis. Most evaluations could be accomplished by a cursory review, others would need to be more comprehensive according to the need.

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[3] Paraphilic Disorders begin on p. 685 of the DSM-V. For all Paraphilic Disorders, the first Diagnostic Criteria is a requirement that the symptoms of the disorder have been present "Over a period of at least 6 months..." Some clinicians will argue that this 6 month period could have taken place anytime in the client's life and not necessarily for the *past* 6 months. However, "A *paraphilic disorder* is a paraphilia that is currently causing distress..." (DSM-V p. 685). Also, such logic would not allow a client to ever be in remission, which is an option for all paraphilic disorders.

[4] "The liberty interest in this case, however, differs materially from the liberty interest at stake in a criminal case. A defendant in a criminal case faces the prospect of a potentially lengthy term of incarceration or even, as in *Ake*, capital punishment. The potential deprivation of liberty in a hearing under Code § 37.2-913 is not a fixed term of incarceration or death, but a revocation of conditional release and short-term civil commitment. Even when an SVP is committed, the commitment only lasts until the next hearing or annual review. *See* Code § 37.2-913(D) (allowing an SVP to petition for re-release no sooner than six months from his return to custody); Code § 37.2-910 (providing for annual review). At their annual review, if they request discharge (p. 11) ... Unlike a defendant in a criminal case, who faces a fixed term of incarceration subject to limited challenge on appeal or on collateral review, an SVP respondent has the opportunity to revisit his commitment. An SVP can petition for re-release no sooner than six months from his return to custody..." (p. 15) (*Thomas v. Commonwealth*, Opinion by Justice Stephen R. McCullough, June 27, 2019).

Conceivably, 6 doctors reviewing two clients each, every day could review the entire population in about 90 days.

Acknowledge and honor the Supreme Court which states that men are entitled to release once they are in remission of a sexual disorder and their conduct is brought under control. (*In re Blodgett*, 510 N.W.2d 910, 916 (Minn. 1994)). The MOSP should be required to assess men according to observable objective and current behaviors instead of their criminal records. All MSOP staff have the tools to monitor every client's incoming and outgoing mail, all non-privileged phone calls, client computer networks, contact and non-contact visiting, and listen to client activity inside cells and team rooms to determine a client's current mental state. Assessors should be mandated to use these policies, which are statutorily required to document the daily behavior of clients, in order to determine the clients *current* mental state. Some of these policies include:

- Clinical Documentation 215-5007
- Client Record Documentation Standards 135-5180
- Client Record Inventory and Security 135-5190
- Client Movement Inside the Secure Perimeter 410-5050
- Searches - Clients 415-5010
- Searches - Areas 415-5011
- Contraband 415-5030
- Duty to Warn 215-1045
- Health Information Record Designation 135-5300
- Intelligence Gathering 145-1020
- Controlled Items and Equipment 415-5041
- Therapeutic and Unit Community Meeting 220-5030
- Therapeutic Recreation Programming 220-5050
- Spiritual Practices 420-5300
- Client Requests and Grievances 420-5099
- Client Physical Identification 210-5105
- Treatment Progression 215-5010
- Individualized Program Plan 215-5015
- Client Record Inventory and Security 135-5190
- Health Services Provision of Care 310-5010
- Psychiatric Services 310-5060
- Facility Counts 410-5051
- Client Behavioral Expectations 420-5010
- Incident Reports 410-5300
- Office of Special Investigations 145-1000
- Curfew 420-5220
- Yard Use 420-5330

- Levels of Observation 215-5270

The reliance on historical record instead of a current presentation of mental state equates to a misdiagnosis. Every one of these policies are designed to make MSOP a secure facility and keep a close eye on a client's every move. However, they are conveniently ignored during the evaluation process. Each policy is authored by a Minnesota Statute and must be obeyed by the client and MSOP staff. Any objective observable evidence of a mental illness of a sexual nature should be documented if it exists. These findings should then be reflected in the Mental Health Assessment or any other assessment that is used to justify continued confinement. In the same way, these policies should be used to indicate if there is NO mental illness.

The legislature should enact a policy similar to the federal statute, 18 USC 4247:

> (c) Psychiatric or psychological reports. A psychiatric or psychological report ordered pursuant to this chapter shall be prepared by the examiner designated to conduct the psychiatric or psychological examination, shall be filed with the court with copies provided to the counsel for the person examined and to the attorney for the Government, and shall include:
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> 1. the persons history and present symptoms;
> 2. a description of the psychiatric, psychological, and medical tests that were employed and their results;
> 3. the examiners findings; and
> 4. the examiners opinions as to sexual diagnosis, prognosis, and
>
> (c) if the examination is ordered under section 4243 or 4246 [18 USCS 4243 or 4246], whether the person is suffering from a mental disease or defect as a result of which his release would create a substantial risk of sexual bodily injury to another person or serious damage to property of another.

In addition, the legislature should create a Judicial Bypass process pursuant to 253D. This can be achieved if a licensed doctor determines the patient has no serious sexual disorder that makes him a danger to himself or others or is in no more need of care in a secure facility. If the licensed doctor recommends a modification of his confinement or outright discharge, the commissioner then can defer to the doctors recommendations and terminate the commitment without court approval bypassing the traditional discharge process pursuant to 253D. The DHS already honors all other licensed doctors, treatment, recommendations, prescriptions and provisions of care from any care facility that is licensed and accredited. The DHS even contracts with Essentia and other care givers. After the evaluation, a Judicial Bypass could be implemented by the commissioner.

(DHS)
Barrier to Release No. 3: The name of the program unnecessarily stigmatizes the men who live there, creating an inherent division between the client and MOSP staff, judges, lawyers and the public.

Stigma is arguably the number one thing keeping men at MSOP. Clients at MOSP experience constant hostility from staff which is caused, in part, by the name of the program.

Potential Solution to Barrier No. 3: Change the name of the program.

Why call someone what you don't want them to be? More so, why call someone something they are not? The name of the program implies that everyone there is a "sex offender". But an "offender" is "[a] person who has committed a crime." [5] Hence, a "Sex Offender" is a person who has been committed of a crime of a sexual nature. However, to receive an indeterminate sentence to the MSOP, a person is NOT required to be convicted of a sex crime. One Minnesota judge, R. A. Randall, is correct when he concurred that for those at MSOP, "...there is no crime involved..."[6] For instance, Daniel Larson has no criminal record, and he has been civilly committed for over 43 years—27 of those years under the current laws where there remains no requirement for a sex offence conviction, yet he is in a program that labels him a "Sex Offender".

(HHSFD)
Barrier to Release No. 4: Many of the mental health diagnosis given to the men at MSOP are not reliable and viable mental health diagnosis according the DSM-V.

There is a large amount of diagnosis that read, "Other Specified Paraphilic Disorder" (OSPD). Standing alone, OSPD does not represent a mental disorder.[7] In addition, unreliable "diagnosis" such as "Paraphilic Coercive Disorder" (PCD) or "Other Specified Paraphilic Disorder (non-consent)", and similar diagnosis that medicalize crime are also used freely at MSOP. These diagnosis always refer to the pre-

[5] *Black's Law Dictionary* 1110 (9th ed. 2009). The state deems a person to have committed a crime upon conviction. Under Minnesota law, "conviction" occurs when the court accepts and records a guilty plea. *See* Minn. Stat. 609.02, subd. 5(1) (2008).

[6] Concurring opinion of R. A. RANDALL , In the Matter of: Gary Alan Mattson, 1995 Minn., C5-95-452, June 20, 1995

[7] Standing alone, OSPD does not represent a mental disorder. The reason for this is that, without a specifier the diagnosis is incomplete and is not generally accepted in the psychological community – the exception being MSOP. OSPD, without a specifier, defies discernible logic. The DSM-V explicitly states, in regard to OSPD and using this category, "This is done by recording 'other specified paraphilic disorder' followed by the specific reason" (emphasis added. p. 705).

commitment behaviors of the man diagnosed.[8] PCD and similar diagnosis have been rejected from the DSM on 4 different occasions.[9] [10] The MSOP uses these *ad hoc* diagnosis frequently. The DSM-V states, "Reliable diagnosis are essential for guiding treatment recommendations..." (p. 5). Therefore, these false diagnosis have no place at MSOP. In his recent commentary on the issue, Allen Frances made this clear:

> SVP cases have brought out the very worst in the always fraught relationship between psychiatric diagnosis and the law. The wording of the paraphilia section, while precise enough for clinical purposes, has proven to be harmfully imprecise when (mis)applied to SVP cases. Until recently, the DSM definition of paraphilia has been consistently misinterpreted by state evaluators to suggest that the act of rape by itself might qualify an individual for the mental disorder diagnosis and trigger an SVP commitment. The most common misdiagnoses have been other paraphilia, nonconsent, paraphilia not otherwise specified, and nonconsent or coercive paraphilia. All of these were once widely, but inappropriately, accepted as legitimate grounds for SVP psychiatric commitment.[11]

The only thing inaccurate about what Frances states is that he seems to think this issue is in the past. For those at MSOP, it is not.

Another diagnosis often used to keep men confined to the MSOP is the Anti-Social Personality Disorder (ASPD). Allen makes his views clear about this also:

> Because ASPD does not allow an offender to avoid prison, it should not later justify his psychiatric incarceration... there are no other circumstances where ASPD is ever grounds for psychiatric commitment or for any other type of psychiatric hospitalization.

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[8] Zinik and Padilla (2016) stated: "There has never been a diagnostic category in any edition of the Diagnostic and statistical manual of mental disorders (APA, 1952, 1968, 1980, 1987, 1994, 2000, 2013) that describes an individual who is persistently aroused by coercive sex and repeatedly commits acts of rape" (p. 1). (Zinik, G. and Padilla, J. (2016). Rape and Paraphilic Coercive Disorder. In Phoenix, A., & Hoberman. H.M. (Eds.), *Sexual Offending: Predisposing Antecedents, Assessments and Management* (pp. 45-66). New York, NY: Springer Science + Business Media.

[9] Frances, A. (February 28, 2011), The Rejection of Paraphilic Rape: A First Hand Historical Narrative. *Psychiatric Times.*

[10] Frances, A. & First, M.B. (2011). Paraphilia NOS, Nonconsent: Not ready for the courtroom. *Journal of the American Academy of Psychiatry and Law 39*(4). 555-561.

[11] Misuse of Diagnostic and Statistical Manual Diagnosis in Sexually Violent Predator Cases, Allen Frances, MD, J Am Acad Psychiatry Law 48: 191-94, 2020. DOI: 10.29158/JAAPL.200020-20, *Volume 48, Number 2, 2020,* Dr. Frances is Professor Emeritus, Duke University, Durham, North Carolina. Address correspondence to: Allen Frances, MD. Email: allenfrancesmd@gmail.com. May 8, 2020

In addition, Z codes are "...not mental disorders..." (p. 715). Yet they are systematically used at MSOP, usually listed as, "Z65.3: Problems Related to Other Legal Circumstances (Civil Commitment)."

Potential Solution to Barrier No. 4: Create an Independent Oversight Committee (IOC) responsible for reviewing all mental health diagnosis at MSOP to establish the conceptual validity[12] of the assigned mental disorders.

The legislature should create an Independent Oversight Committee (IOC) that understands the dangers of medicalizing crime and using *ad hoc* categories of "mental illnesses". The IOC must have the highest standard of review when examining diagnostics where liberties are at stake. The IOC must be independent from the Department of Human Services. The IOC must be responsible for reviewing all mental health diagnosis at MSOP and establish the conceptual validity of the assigned mental disorders. The IOC must be made up of at least 4 individuals:

1. one Board-Certified forensic psychologist
2. one Board-Certified forensic psychiatrist
3. one member from the National Alliance on Mental Illness (NAMI)[13]
4. one individual from an official client advocacy group[14]

The IOC must use the Diagnostic and statistical Manual of Mental Disorders, 5th Edition (DSM-V) to determine the validity of the diagnosis.

(HHSFD)
Barrier to Release No. 5: For all intents and purposes, all members of the SRB are appointed and directly compensated by the DHS and are contracted employees of the DHS. Therefore, The DHS is not an impartial entity to any CAP proceeding. Rather, its Commissioner is a participatory "party."

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[12] The phrase conceptual validity discriminates between what is a disorder and what is not a disorder. (Wakefield, J.C. (2003). Clarifying the distinction between disorder and nondisorder. In K.A. Phillips, M.B. First, & H. A. Pincus (Eds.) *Advancing DSM: Dilemmas in psychiatric diagnosis* (pp. 23-55). Washington, DC: American Psychiatric Association.

[13] 1919 University Ave. W. Ste. 400, St. Paul, MN 55104 Tel. (651) 645-2948 or for the director of NAMI in Minnesota, Sue Abderholden, call (651) 440-3829. Email: sabderholden@mn.org. namimn.org or namihelps.org.

[14] Currently, clients work closely with two organizations, the Twin Cities Inmate Worker Organization Committee (TCIWOC), and the Citizens United for the rehabilitation of Errants Sex Offenders Restored Through Treatment (CURE-SORT). The MSOP client representative from TCIWOC is David Boehnke, email: dboehnke@gmail.com. Tel: (651) 315-4222, (612) 405-0347 and the client representative from CURE-SORT, is Eldon Dillingham, email: eldoncdillingham@gmail.com. Tel: (785) 458-9546

Per Minnesota statute, all committed persons seeking a reduction in custody must first file a petition with the Special Review Board (SRB). All panels of the SRB are established by the Commissioner of the Department of Human Services (DHS). Any recommendation of the SRB is mandatorily reviewed by the Commitment Appeal Panel (CAP). Although not directly affiliated with the DHS, all members of the SRB are appointed and directly compensated by the DHS. Thus, for all intents and purposes, they are contracted employees of the DHS for the purpose of the SRB hearing. Likewise, all compensation of the judges serving on the CAP (on top of their regular salaries) are paid for by the DHS. The DHS is not an impartial entity to any CAP proceeding. Rather, its Commissioner is a participatory "party." (See Ballantine's Law Dictionary, 3rd edition, 2002, defining a "party" as "one of the opposing litigants in a judicial proceeding"). In the nearly 30 year history of the MSOP, the DHS has used this party status to oppose the discharge of nearly every person who has ever petitioned for discharge from the program, regardless of treatment progress or lack of evidence of a current mental disorder causing sexual dangerousness. Accordingly, per the natural rubrics of capitalism, it would appear that the CAP judges have been placed in a situation containing an inherent "conflict of interest" detrimental to the position of committed persons in the program. Furthermore, all fees and costs of counsel appointed to represent committed persons in custody reduction proceedings are both established and paid by the DHS. Compensation of the committed person's counsel by the opposing side would also seem to create a disadvantageous "conflict of interest" to his position. For these reasons, the statutory scheme enacted by the Minnesota Legislature blatantly undercuts the right of committed persons to the right of a fair trial guaranteed by the Minnesota and United States Constitutions.[15]

[15] "Commissioner means the commissioner of human services or the commissioners designee." (253D.02, Subd. 3.) "...reduction in custody means transfer out of a secure treatment facility, a provisional discharge, or a discharge from commitment..." (253D.27 Subd. 1. (b)) "A petition for a reduction in custody... must be filed with and considered by a panel of the special review board authorized under section 253B.18, subdivision 4c..."(253D.27 Subd. 2.) "...the special review board shall issue a report with written findings of fact and shall recommend denial or approval of the petition to the judicial appeal panel established under section 253B.19... No reduction in custody... recommended by the special review board is effective until it has been reviewed by the judicial appeal panel..." (253D.27 Subd. 4) "A person committed as a sexually dangerous person or a person with a sexual psychopathic personality... may petition the judicial appeal panel established under section 253B.19, subdivision 1, for a rehearing and reconsideration of a recommendation of the special review board..." (253D.28, Subd. 1. (a)) "...the commissioner shall participate as parties to the proceeding pending before the judicial appeal panel..." (253D.28, Subd. 2. (b)) "The commissioner shall establish one or more panels of a special review board... No member shall be affiliated with the Department of Human Services. The special review board... shall hear and consider all petitions for a reduction in custody... Members of the special review board shall receive compensation and reimbursement for expenses as established by the commissioner." (253B.18, Subd. 4c. (a)) "The Supreme Court shall establish an appeal panel... The chief justice of the Supreme Court shall determine the compensation of the judges serving on the appeal panel. The compensation shall be in addition to their regular compensation as judges. All compensation and expenses of the

Potential Solution to Barrier No. 5: Remove the DHS as a party to the discharge process.

The county of financial responsibility should take full responsibility and accountability of whether to oppose or support the discharge petition. In addition an Independent Judiciary created by The Minnesota Supreme Court, as opposed to the DHS, should be implemented.

(DHS/MSOP)
Barrier to Release No. 6: There is no client/staff transparency.

There are many situations where the client is forced to "trust" the clinician not to exaggerate, misunderstand or outright lie about a client. The entire treatment process relies on the honor system. However, the scales are uneven in this relationship. In groups and modules, the clinician(s) sit with multiple men discussing treatment related issues. The clinician(s) take notes throughout the meeting. These notes are then typed into the client treatment charts as Therapy Group Participation Progress Notes. These notes, along with Incident Reports and Communication Logs, end up in Quarterly Treatment Progress Reports and Annual Treatment Progress Reports. This is the same for any individual sessions which the clinician records in the form of Individual Progress Notes. Also, the clinician sits with clients individually for Mental Health Assessments and also takes notes there. All of this information eventually ends up at the Special Review Board (SRB) and is used by MSOP's lawyers to keep the client confined. This gives an unfair advantage to the MSOP.

Potential Solution to Barrier No. 6: Provide clients the option to have their otherwise private interactions with staff video and audio record.

Give clients an option to sign a waiver to have their groups, individual sessions, annual meetings, quarterly meetings, and any other vulnerable interactions between MSOP staff and clients video and audio recorded. This is exactly what is done at the SOTP treatment program in the Lino Lakes prison. The recordings of the client's otherwise secret interactions with MSOP staff are available for that client at the end of each quarter. Each time a client obtains a copy of the recording, the more the client can trust the process. This is likely to inspire more clients to participate in treatment.

appeal panel and all allowable fees and costs of the patients counsel shall be established and paid by the Department of Human Services." (253.19, Subd. 1.)

(DHS/MSOP)
Barrier to Release No. 7: The process for allowing family and public officials to participate in RAFC meetings is too complicated and MSOP administration almost never approves of any recommendation made by RAFC.[16]

Potential Solution to Barrier No. 7: Utilize the secure ITV system already in place at the MSOP to allow family and public officials to participate in RAFC and at least one MSOP administrator should be required to attend one RAFC meeting a month to participate in the discussions.

(DHS/MSOP)
Barrier to Release No. 8: There is no sense of hope at MSOP.

The culture and overall ambiance of MSOP is one of absolute hopelessness. Client progression is never announced to the general client population. In contrast, client deaths are always announced.

Potential Solution to Barrier No. 8: Abolish the tier system, which is prohibited by law[17] and the Behavioral Expectations Reports (BER). Re-introduce the Primary Resource Person (PRP) and the OP-Team systems. Announce client treatment progression to the entire client population. Create a policy outlining the process for a graduation ceremony. Provide proper reintegration services at both MSOP sites including accredited college courses and jobs training courses.

Minnesota Rule prohibits, "using token reinforcement programs or level programs that include a response cost or negative punishment component." In addition, abolish the Behavioral Expectations Reports (BER) and return to having a Primary Resource Person (PRP), which is when a Security Counselor, assigned to a certain number of clients, meets with them periodically to do check-ins and build pro-social rapport. In addition, Op-Teams should be implemented which is what the BER process replaced. The Op-Team, PRP and clinical would meet with the patient to discuss the rule violation, behavior, etc. to then give an assignment as opposed to BERs.

MSOP staff should be required to announce to the general client population when a client has achieved any type of progression in the program including:

1. Phase Progression

[16] According to the Resident Advisory and Family Council (RAFC) 220-5035 policy, "Each ...[MSOP] site may have a Resident Advisory and Family Council (RAFC), which provides a method for clients to meet and make recommendations to MSOP administration regarding facility policies..."
[17] MN Rules, CH 9544, 9544.0060, PROHIBITIONS AND RESTRICTIONS, Subp. 2.Specific prohibitions, Q.

2. Court order to Community Preparation Services (CPS)
3. Court order of Provisional Discharge
4. Court order of Full Discharge

If the law requires the client's name to remain private, an opportunity for the client to waive confidentiality rights for the purpose of announcing their progression should be offered.

A policy should be created outlining the process for a graduation ceremony procedure for those that have completed a preapprove treatment plan in accordance with the individual needs of the client, whether they are being fully discharged from the facility or not. The graduation policy should include a ceremony, perhaps in the gymnasium of either MSOP site, or some other large room. A number of family and friends of the MSOP graduate should be allowed to attend the ceremony. A certificate of completion should be presented to the graduate, signifying that the accomplishments do not need to be repeated. Other festive elements should be incorporated at the ceremony as to encourage and inspire other clients to also achieve graduation at MSOP. In addition, MOSP should be required to provide proper reintegration services at both MSOP sites.[18] Proper rehabilitation services should include accredited college courses and jobs training courses.

(MSOP)
Barrier to Release No. 9: Jannine Herbert confessed, "... [W]e made a conscious decision to move away from that medical model approach..."[19]

Herbert goes on to say, "And when I say medical model, for example, medical model is very hospital-based..." When Herbert had completed the transformation, MSOP was, "...very much not a medical model design..." Herbert says.[20] The United States Supreme Court has stated that civil commitment is not justified, "...absent some medical justification for doing so..."[21] But MSOP administration admits, "The vast majority of patients committed to the Minnesota Sex Offender Program do not experience symptoms of mental illness..."[22] Therefore, MSOP Executives have deleted a program that supports a state interest in rehabilitating the mentally ill, and replaced it with a psychoeducational treatment that addresses the same criminogenic factors previously addressed in the prison system.

[18] In theory, when a client is fully discharged from MSOP, they would leave from the St. Peter site. However, at least 4 clients where fully discharged from the Moose Lake site. (Jacob Rask, Eric Eischens, and Isaiah Swedeen).
[19] *Karsjens v Jesson*, Case No. 11-CV-3659 (DWF/JJK), March 5, 2015, pp. 4001, 4002
[20] *Karsjens v Jesson*, Case No. 11-CV-3659 (DWF/JJK), March 4, 2015, pp. 3882 – 3884
[21] *Foucha v Louisiana* (1992) p. 83 Justice O'Connor concurring
[22] Variance Request Application for Rule 9515.3030, Subp. 2. Psychiatric evaluation

Potential Solution to Barrier No. 9: Convert the MSOP back to a Medical Model treatment and obtain the appropriate accreditation for medical facilities.

In addition to licensure, facilities can voluntarily seek accreditation from a national organization, reflecting compliance with professional standards. The main health care accreditation body is the Joint Commission (formerly called the Joint Commission on Accreditation of Healthcare Organizations). The Minnesota Department of Health accepts accreditation by the Joint Commission as proof that a facility complies with MDH regulations necessary to obtain state licensure as a hospital. The Joint Commission is responsible for routinely monitoring hospitals' continuing compliance with accreditation (and therefore state licensing) standards as well as investigating complaints it receives.[23] For the most part, the Joint Commission's standards reflect state licensing standards, setting forth administrative, staffing, program, and physical plant requirements that facilities must meet. The health department does not usually monitor or inspect the accredited hospitals that it licenses, relying largely on the Joint Commission to conduct routine inspections, monitor compliance, and investigate complaints filed with the Joint Commission.

(HHSFD)

Barrier to Release No. 10: Men at MSOP believe MSOP is billing the federal government for "Chemical Dependency" treatment, although MSOP does not offer such treatment.

Men at MSOP have reason to believe that their county workers are certifying DHS administration to bill the federal government for "Chemical Dependency" treatment, although MSOP does not offer such treatment. If the federal government did not approve this funding, MSOP would be forced to release many of their clients.[24]

Potential Solution to Barrier No. 10: An organization, independent from DHS, should investigate whether or not MSOP receives funding fraudulently.

[23] As with state licensing visits, Joint Commission accreditation visits are unannounced. Joint Commission accreditation is generally good for a maximum of 36 months

[24] For example, using a form called an, "Intra-County Notice of Chemical Dependency IMD Placement" form (DHS 4125-ENG), Aitkin County worker Nicholas Anderson [ph: (218) 927-7200] authorized the DHS to charge the federal government for "Chemical Dependency" treatment when in fact, they are paying for "sex offender treatment" at the MSOP. On the form under "Provider Name", "MSOP-ML" is marked. In the space "MMIS National Provider Identifier (NPI) number (from CPA)" the code "1730354549" clearly indicating that county workers across Minnesota are authorizing the MSOP to fraudulently collecting funds from the federal government for "Chemical Dependency" treatment.

The organization should also confirm whether or not MSOP receives any kind of federal funding, whether by fraud or not. If they do, this information should be made available to clients and the public to promote transparency.

(DHS)
Barrier to Release No. 11: An estimated 45-60 men at the Moose Lake site are CPS status, but are still waiting to move to St. Peter.

Once an individual obtains Community Preparation Services (CPS) status by the Judicial Appeal Panel, they are entitled to be transferred to St. Peter within 15 days.[25] An estimated 45-60 men at the Moose Lake site are CPS status, but are still waiting to move to St. Peter.

Potential Solution to Barrier No. 11: Transfer all men to St. Peter who are on CPS status, and are statutorily entitled to transfer.

(MSOP)
Barrier to Release No. 12: MSOP clients are not taught victim empathy, which is a crucial element of an effective treatment program.

Potential Solution to Barrier No. 12: Bring Restorative Justice to MSOP to provide the tools clients need to build empathy for others and to raise money for sexual assault survivors. [26]

(DHS)
Barrier to Release No. 13: There are about 50 juvenile offenders and 468 men over the age of 46 at MSOP. These unnecessary demographics have created a bottle neck effect that has made it physically impossible for staff to progress individuals as there would be no room in St. Peter.

Potential Solution to Barrier No. 13: Release and reintegrate all 50+ juvenile offenders immediately. Assess all 468 men who are over the age of 46, using modern assessment tools that consider the "aging out" factor which has shown that an offender's likelihood to reoffend consistently declines as they get older.

Release and reintegrate all juvenile offenders immediately and abandon the idea that every single person has to go through St. Peter to be safe enough to go home. An offender's likelihood to reoffend becomes less and less as they get older. Once a man hits the age of 45, they have naturally aged out of "highly likely" to reoffend. There are 468 over the age of 46 at MSOP and by the end of the next decade, over half of the

[25] 253B.19, Subd. 3, Decision.
[26] Contact Michelle MacDonald, Attorney & Restorative Justice Facilitator, email: michelle@familyinnocence.com, Tel: (612) 554-0932

MSOP population will be senior citizens. MSOP should Assess all 468 men who are over the age of 46, using modern assessment tools that consider the "aging out" factor and begin releasing the older population, even if they are leaving from the Moose Lake site. (See article attached, "**AGE IS THE MOST IMPORTANT ELEMENT**")

(DHS/MSOP)
Barrier to Release No. 14: Professionals have made their opinions known about MSOP, yet they have routinely been ignored.

Potential Solution to Barrier No. 14: Listen to, and respect the auditors & experts who have investigated the program. Employ the science and the facts for creating an effective program.

The following articles and audits are worth considering to find ways of overcoming the barriers men face when seeking release from MSOP:

1. On October 9, 2013, the MSOP Task Force broadly agreed that MSOP patients should be afforded regular independent review to ensure that they are properly placed in the program.
2. Look at the list of suggested remedies at the end of the document: Legislative Auditor, Evaluation Report, Civil Commitment of Sex Offenders, James R. Nobles, (March 2011), Office of the Legislative Auditor, Program Evaluation Division, Centennial Building, Suite 140, 658 Cedar Street, St. Paul, MN 55155-4708. E-mail: auditor@state.mn.us, Web Site: http://www.auditor.leg.state.mn.us. Phone: (651) 296-4708.
3. *Karsjens v. Jesson* has a number of Amicus briefs where professionals have offered solutions. Some include:

    I. Amicus Brief for Criminology Scholars and the Fair Punishment Project, *Karsjens v Jesson* (June 22, 2017) Ronald Sullivan, Harvard Law School, Cambridge, MA 02138, Tel.: (617) 496-2054, email: rsullivan@law.harvard.edu
    II. Brief of Amici Curiae Eric S. Janus and ACLU-MN, *Karsjens v Jesson,* Court File No. 11-CV-03659 (DWF/JJK), Doc. 408, Filed 12/27/13
    III. On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit, MOTION AND BRIEF OF THE ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS AS AMICUS CURIAE IN SUPPORT OF PETITIONERS, *Karsjens v Jesson,* (June 2017), Adam W. Hansen, APOLLO LAW LLC, 400 South 4th Street, Ste. 401M-250, Mpls., MN 55415, Tel: (612) 927-2969, email: adam@apollo-law.com

IV. *On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit, BRIEF FOR THE CATO INSTITUTE AND REASON FOUNDATION AS AMICI CURIAE IN SUPPORT OF PETITIONERS, Karsjens v Jesson, June22, 2017, Bidish Sarma, 2126 Tenth Street, Berkeley, CA 94710, Tel: (504) 535-0522 and* Ilya Shapiro, CATO INSTITUTE, 1000 Mass. Ave. N.W., Washington, D.C. 20001, Tel: (202) 842-0200, email: ishapiro@cato.org

V. EXPERT REPORT OF MICHAEL F. CALDWELL, PSY.D., Court File No. 11-cv-03659 (DWF/JJK)

VI. REPLY EXPERT REPORT OF MICHAEL F. CALDWELL, PSY.D., Court File No. 11-cv-03659 (DWF/JJK)

VII. EXPERT REPORT OF DEAN R. CAULEY, PH.D., MBA, Court File No. 11-cv-03659 (DWF/JJK)

VIII. REPLY EXPERT REPORT OF DEAN R. CAULEY, PH.D., MBA, Court File No. 11-cv-03659 (DWF/JJK)

(HHSFD)
Barrier to Release No. 15: Many examiners have been retained at the substantially discounted rate of $100 per hour, effectively agreeing to work pro bono ("for the good") of the CAP/DHS. This creates a bias in favor of the DHS.

During the process of periodic review, a dependable medical evaluation of a committed person's mental health is essential to answering the question of whether his present mental condition necessitates continued civil commitment. The court administrator (of the Appellate Courts) maintains a list of examiners to serve the CAP in every reduction in custody proceeding. Although the Special Rules state these examiners are to be paid at a rate of compensation fixed by the court, Minnesota statutes mandate the DHS to establish and pay all associated compensation and expenses of the Appeal Panel. The current rate of compensation established for examiners appointed from the prepared list is $100 per hour. In stark contrast, according to information obtained from Dr. Fred Berlin (founder of the National Institute for the Study, Prevention and Treatment of Sexual Trauma, at the Johns Hopkins School of Medicine, Baltimore Maryland), the expected hourly rate nationwide for examiners in civil commitment proceedings is $400-500 per hour. Consequently, any examiner retained at the substantially discounted rate of $100 per hour has effectively agreed to work pro bono ("for the good") of the CAP/DHS. The appointment of an evaluator at a rate of compensation far below his or her fair market value engenders a genuine risk that the expert may not perform a thorough assessment—pursuant to the requisite standards and practices of the psychological profession—of the committed person's mental health. Furthermore, it creates a reasonable possibility of the examiner having an implicit or explicit bias towards the position of the DHS—the party paying the pro bono salary the doctor has

agreed upon. This circumstance unavoidably creates an unjust obstruction to the committed person's liberty interest in being free from unnecessary civil confinement.[27]

Potential Solution to Barrier No. 15: Remove the DHS as a party to the discharge process so that county's will take full responsibility to oppose or support the discharge petition.

(HHSFD)
Barrier to Release No. 16: The Special Review Board hearing is merely administrative in nature, with the Board having no independent authority to approve any reduction in custody.

The SRB may only submit an advisory recommendation to the Commitment Appeal Panel, which actually conducts legal judicial proceedings. Thus, the requirement to first appear before the SRB results in an unwarranted delay in time for the committed person, and creates an unnecessary expense for the State.

Potential Solution to Barrier No. 16: Eliminate the statutory requirement of the SRB hearings, and reassign MSOP forensic evaluators to perform periodic SVRA's of the Program population. Patients should then be able to petition for reduction in custody directly to the CAP.

[27] "The court administrator shall prepare and maintain a list of examiners... Examiners shall be paid at a rate of compensation fixed by the court... Examiners in judicial appeal panel proceedings shall be appointed and compensated as provided in Minnesota Statutes, section 253B.19." (Special Rules of Procedure Governing Proceedings Under the Minnesota Commitment and Treatment Acts, Rule 11. Examiner's List) "Court examiner means a person appointed to serve the court..." (253B.02, Subd. 7a) "... All compensation and expenses of the appeal panel... shall be established and paid by the Department of Human Services." (253B.19 , Subd. 1.)