the **Legal Pad** — *tLP* Volume 8, Issue 8 — August 1, 2024

"Unlimited power in the hands of limited people always ends in cruelty." – Aleksandr Solzhenitsyn

In This Issue:

1. SOLPRC Conference Draws Together Experts & Activists to Discuss Sunsetting MSOP & Reinvesting Its Annual Cost Elsewhere. 1-2
2. Minnesota Law Restructures Overlords Governing Its SOCC System: Big or Little Effect; Good or Bad? 2-4
3. What's a Baldrige? Could Misuse of Award Whitewash MSOP Problems and Target It for Privateer Takeover? 5-6
4. What Happens to State SOCC Systems Relegated to Private Contractors? Can You say Nightmare Without End? Check Out These Nightmares without End. 6-7
5. "Special Measures": SOCC Is Not Needed, Is Pointlessly Punitive & Unhelpful. 7-10
6. MSOP Confinees Get Free Phone Calls Back, But New Restrictions Make Meaningful Communication Nearly Impossible. 10
7. CURE National Civil Commitment Project Says: End SOCC Everywhere Now! 10

Coming Soon:

- ✓ Free Speech in Campus & SOCC
- ✓ Sex Offender Residence and Employment
- ✓ What Does Barring Inter-SO Associations Actually Result in?
- ✓ Estimating # of Unreported Sex Crimes Is Junk Science: Scurich & John vs. Abbott, Lave *et al.*
- ✓ Remorse Bias — What's THAT?
- ✓ RNR vs. Good Lives vs. Virtue Ethics vs. Desistance: Which Best Matches Offender Rehabilitation & TJ? Any bets?
- ✓ Lie-Detector Interrogation & Peter Meter Testing: Keeping You Down by False Hope, Fear, & Shame
- ✓ 'All Except for' Blanket Exclusions of SOs from Justice Reforms
- ✓ Banishment by 1000 Laws
- ✓ Levenson on Needs-Preferences of Clients of SO Treatment
- ✓ Dynamic Risk Factors and RNR Theory (2-part series) – Pt 1 - DRFs
- ✓ Due Process Requires Courts to Examine Scientific Evidence Undermining Statutes
- ✓ 'New' SORN Laws Are Punitive
- ✓ Panic in the Statehouse: Bad Policy by Panicked Legislation
- ✓ SO Reintegration - Environmental Ingredients Are Known; Officials Just Need to Use the Cookbook.
- ✓ History of SOCC Laws & Rejection of 'Rapism'
- ✓ Will CA Expand Tier Reduction for 1000s of Registrants?
- — & Many more to come!

Free Downloads of all *tLP* editions:
* http://www.cure-sort.org/mn---the-legal-pad.html
* http://wapercyfoundation.org/

Feedback? News? Write!

tLP Editor Address (Exactly & **Only** as Below):

Cyrus P. Gladden II
1111 Highway 73
Moose Lake, MN 55767-9452

Con·fer·ence: ***n. The act of conferring or consulting, esp. on an important or serious matter.***

Conference of 175 Experts, Stakeholders & Decision-Makers Resets the Bar of Seriousness of Deliberating When & How to End MSOP.

Wilson on SOLPRC June 7, 2024 Conference

Daniel Aaron Wilson-Raj, "Hey, Detainees: You're Much More Powerful Than They Want You to Think." *Direct submission* (July 11, 2024) Text: "**We Did This Together**

Before we go into detail about the conference, we want to thank the detainees who helped make the conference possible. Be proud of yourself. We did this together.

What Conference?

The name of the conference was 'Investing in Safety and Survivors: A Discussion of Sexual Violence Prevention and Accountability in Minnesota.' It was an all-day event at Mitchell Hamline School of Law in St. Paul, Minnesota on June 7, 2024. Organizing the event was spearheaded by the 100 Million Dollar Committee, a group assembled after the hunger strikes and EndMSOP protests in the summer of 2021.

So What Did They Talk About?

The conference centered on the April 2024 report by Mitchell Hamline School of Law entitled, "Sex Offense Civil Commitment: Minnesota's Failed Investment and the $100 Million Opportunity to Stop Sexual Violence." The conversation was about how we might allocate money from MSOP to effective prevention programs in Minnesota when MSOP is terminated. MSOP fails to accomplish its goal to prevent sexual violence, so many professionals see it for what it is: a failed program, -- not only because it fails to release people – but because it fails to protect the public from sexual violence and robs other programs that do.

Who Was There?

About 170 people attended the conference. Many more wanted to attend, but there was no room. The keynote speaker was Eric S. Janus, Minnesota's leading expert in sex offense policy. Jannine Hebert, MSOP Clinical Director and Kathryn Lockie, MSOP Health Care Program Manager showed up, but didn't stay long. Also in attendance were lawmakers' aides, victims/survivors of sexual harm, legal and policy professionals, reentry specialists, families of detained persons, mental health advocates, human rights advocates, facial justice advocates, treatment providers, officials from the Department of Corrections, doctors, lawyers, lobbyists, and TITUS, a nonprofit organization dedicated to ending MSOP, Even some of the original developers of MSOP were there to consider the benefits of sunsetting the MSOP and reallocating the money to effective prevention programs."

****

SOLPRC-MnCASA Conference on the Importance of Sunsetting MSOP and Reinvesting its Exorbitant Cost to Prevent Sex Crimes: the Participants and the Program Materials Say It All.

Mitchell Hamline Sex Offense Litigation and Policy Resource Center & Minnesota Coalition Against Sexual Assault, Investing in Safety and Survivors: A Discussion of Sexual Violence Prevention and Accountability in Minnesota (June 7, 2024): Conference materials.

"**About the Sponsors**

The Minnesota Coalition Against Sexual Assault (MNCASA) is a statewide coalition driving transformative culture change to address sexual violence through advocacy, prevention, racial justice, and systems change and policy. [MNCASA describes its four focus areas thus: "Advocacy: We promote trauma-informed care and provide leadership and resources to advocates in providing services to all victims/survivors in their communities. Prevention: We work to prevent harm and address root causes of sexual violence using an anti-oppression lens. Policy & Systems Change: We invest in community-focused work alongside efforts to transform systems, prioritizing underserved communities. Racial Justice: We work toward a Minnesota where BIPOC victims/survivors have access to safety, affirmation, and systems they can trust and use."]

The Sex Offense Litigation and Policy Resource Center (SOLPRC) at Mitchell Hamline School of Law collects and disseminates information about cases on issues of sexual violence policy, and facilitates communication, sharing, and the development of strategies among the lawyers, advocates and academics who seek a more sensible and effective public policy on sexual violence prevention.

***

Information Regarding the $100 Million Committee

SOLPRC acknowledges the critical role that the $100 Million Committee has played in producing the Report, organizing this Conference, and advocating for Sunset and Reinvest. The $100 Million Committee seeks to dramatically reduce sexual violence in Minnesota by sunsetting the Minnesota Sex Offender Program ("MSOP") and reinvesting the $110 million per year operating budget into programs and interventions that prevent sexual violence and address the harm it causes. Assembled after the hunger strikes and EndMSOP protests in 2021, the Committee is composed of detainee representatives, victims/survivors of sexual harm, legal and policy professionals, reentry specialists, families of detained persons, and mental health, human rights, restorative, and racial justice advocates. Members of the $100 Million Committee contributed to the April 2024 report on sex offense civil commitment in Minnesota, published by the Sex Offense Litigation and Policy Resource Center at Mitchell Hamline School of Law, and helped to plan today's conference. If you would like to get involved with the $100 Million Committee to sunset/reinvest MSOP and devise legislation for 2025, sign up at the registration table.

***

Please note that today's conference will not be recorded or livestreamed.
We ask that participants respect that decision."

***

Discussion Panels:

Victim/Survivor Support:
- Liz De La Torre[1]
- Jude Foster[2]
- Ashley Taylor-Gouge[3]

Primary Prevention and Education:
- Hunter Beckstrom[4]
- Pogi del Rosario[5]
- Wilson Yang[6]

Treatment and Reentry:
- Mark Bliven[7]
- Ronda Disch[8]
- Bill Donnay[9]
- Katie Holmgren

Interim Steps:
- Dr. Michael H. Miner[10]
- Andrew Pieper[11]
- Judge Jay M. Quam[12]
- Jen Thon[13]

Panelist notes:

1. Sexual assault advocate, crisis counselor, & organizer
2. Crisis services developer, coordinating, training & tech services
3. Rape crisis center associate director
4. Prevention program coordinator & developer

(Continued on page 2)

5. Prevention program coordinator
6. School-Based Services supervisor, electoral organizer
7. MN DOC Risk Assessment/Community Notification Director
8. Exec. Director, Alpha Emergence Behavioral Health
9. MN DOC Risk Assessment/Community Notification Director (ret.)
10. Univ. Of Minn. Prof Emeritus: Family Medicine & Community Health
11. Litigation Partner: Stoel Rives LLP, successful representation of MSOP confinees
12. 4th District & CAP judge, Univ. Minn. adjunct professor in Law & Forensic Psychology
13. Attorney, Jones Law Office, Mankato, MN, specialist in commitment defense

MN Sexual Offender Treatment Facts of Note*:

Arrest/Conviction Statistics:

2022: 619 convictions

2021: 1,415 persons convicted of sex offenses

2023: 1,152 sex offense arrests (including minor obscenity exploitation cases)

Arrest/Conviction Statistics:

DOC Supervision: 2,624 persons (for sex offenses)

Probation: 3,483 persons (for sex offenses)

Total Supervised: 6,107 persons needing community treatment

DOC Sex Offender Treatment Data:

Available Treatment Beds: 303 in DOC facilities

Average Treatment Length: 17.3 months

Current DOC Clients with Treatment Mandate: 1,839 persons (for sex offenses)

Treatment Completion Rates (2019-2023):

- Entered treatment while incarcerated: 34%
- Successfully completed treatment before release: 16%
- This means 84% will need treatment post-prison-release.

Key Crisis Insights

Burgeoning need population: Over 1,000 new sex offense convictions/arrests annually. Contributing to community treatment burden.

Underfunding: Per-client costs far exceed available funding.

Inadequate treatment capacity: Thousands need services, but only 303 beds available within DOC facilities, leaving the vast majority to post-release community providers unable to handle such numbers.

Low treatment completion: Many don't complete treatment while incarcerated, increasing post-release need

High supervision numbers: With over 6,000 persons supervised for sex offenses, the demand on community-based treatment providers is high and growing.

What Is Needed:

Increased Funding

Expansion of Treatment Programs

Support for Providers

[*Note: The foregoing focuses only on the treatment aspect of the needs. Prevention programs present substantial additional unmet needs.]

Additional Comments on the Lack of Treatment Funding by the Minnesota Association for the Treatment and Prevention of Sexual Abuse:

"Conversations with seven of the outpatient treatment programs that serve the state of MN, who represent nearly all of the outpatient clients served statewide, had this to say about funding challenges faced by their programs:

All agencies have funding concerns

- Nearly 100% of convicted sex offenders are financially unable to pay their court-ordered treatment without assistance
- Health insurance reimbursements often barely cover minimum wage for staff, much less the cost of agency operations
- County and State correctional subsidies have dollar caps per year, are subject to cuts at any time, and are never enough to fully fund an agency to do the required work
- Sex offender treatment agencies are not often awarded charitable donations
- Agencies are **living from paycheck to paycheck**, and at times using operational reserves to stay open
- Agencies are increasingly making business decisions based on finances because **a business model based on best practices has not been sustainable**
- Every agency polled is concerned about the sustainability of outpatient treatment if funding does not dramatically change

A closer look at relying on health insurance to fund sex offender treatment:

- Insurance caps their payment for services much lower than the agency's rate/service....
- MA/Medicare/Medicaid pays even less
- Contracts with health insurance disallow programs from charging the remaining amount to any third party (including state/county correctional funders) [this is probably to allow the insurer to recoup its outlays by subrogation against the correctional or other governmental entities involved]
- Health insurance reimbursement rates have stayed consistent for more than 15 years....
- Thus programs write off hundreds of thousands of dollars annually in uncollectible revenue
- Agency operating costs rise years after year....
- Liability insurance for sex offender treatment agencies are 30% higher than general mental health agencies
- High deductible insurance plans are becoming more and more normal for employed clients ($5000-7000/year), essentially meaning clients have no coverage for their treatment services....

Noteworthy: Sex offender treatment, when done within a facility (DOC or DHS), is not subject to any insurance billing whatsoever; it would be entirely unsustainable. Community-based treatment providers, ...are expected to treat more people with far less resources. Instead of being able to hire and retain the best and most experienced therapists, our system to generate revenue (fee-for-service) cripples our ability to pay staff.

Impact & Conclusions:

- Outpatient sex offender treatment staff are underpaid, impacting retention of skilled therapists in the field and the ability to hire new staff....
- In this hiring climate, low pay leaves positions unfilled, clients waitlisted (not being seen for their court ordered services) and existing staff burning out at higher rates.
- The fee-for-service reimbursement model does not work to sustain outpatient treatment agencies

Outpatient sex offender treatment agencies need:

- ...Funding that allows for program sustainability
- Funding commensurate with the public safety services we provide
- Barriers to client access to be eliminated."

[Editor's Closing Note: Effectively the important work of these agencies in working with all Minnesota sex offenders is thwarted and existentially threatened by the 'steal' of the massive funds taken to continue the worthlessly wasteful and fruitlessly failed MSOP boondoggle. Sunset, closure, and reinvestment are urgently needed now!]

****

When Is an Agency Equal to a Department?

A 2024 Law Modifies and Amplifies on 2023 Legislation Elevating DCT to the Equal of a Minnesota Department, Only Different.

by Cyrus Gladden

2024 Minnesota Session Laws, Chapters 79 and 125 Liberate DCT -- Including MSOP – from DHS and Set Numerous Changes

The 2023 Minnesota Legislature addressed the operational problems plaguing the Department of Human Services ("DHS"), which critics asserted had become too big to administrate effectively. The Department of Direct Care and Treatment was statutorily created as Chapter 246C of the Minnesota Statutes by Laws of 2023 chapter 61 (sometimes herein, the "2023 Act"), effective July 1, 2023. Previously, Direct Care and Treatment ("DCT") was a "division" within the Department of Human Services of the State of Minnesota. As an uncommon feature of Minnesota bureaucratic structure, Section 246C.02(a) decreed that "an executive board shall head" the new Department. Section 246C.03, Subdivision 1 allowed the Commissioner of Human Services to continue to "exercise all authorities and responsibilities under relevant statutes, pending legislation anticipated in 2024 that would develop the powers and duties of the executive board of the new Department of DCT. Subdivision 2(b) clarified that the executive board of the Dept. of DCT must consist of no more than five members.

However, since the end of the 2023 legislative session, debate and further contention have persisted about the exact provisions that should shape and govern DCT as a separate governmental entity. In the 2024 legislative session, legislators first passed Act (Chapter) 79 on the subject. However, after further debate, a new bill revisited the subject, effectively starting over in the re-definition of DCT. That bill was also passed, becoming Act (Chapter) 125. Because this re-write changed so much, it is best to start with the superseding Act 125, adding comment as to what from Act 79 was left in place.

Intriguingly, 2024 Act 125 now denominates DCT as an "agency" of Minnesota state government. In the structure of Minnesota government, all state departments are agencies but not all agencies are departments. Act 125 excludes DCT from being a department without expressly stating why. A likely part of the rationale for this is the extraordinary arrangement of having DCT policy be decided upon by its governing executive board; Direct Care and Treatment, unlike state departments, does not have a ruling "commissioner." Instead, the head administrator of DCT is given the title, "Chief Executive Officer" – very much like a corporate head executive. Just like a corporate "CEO" reports to the corporation's board of directors, DCT's CEO reports to its executive board. A leading reason why DCT was organized in this way dates back to the professional history of the (formerly DCT "Division") head, Marshall E. Smith. He comes from a background of hospital executive administration, having previously held that title in that role. As for-profit hospitals are essentially a business, Mr. Smith brings business skills of organization and efficiency refreshingly beyond those of most Minnesota government agencies. It isn't hard to understand why he prefers to continue working in that role, so familiar successful for him.

Another reason for legislatively denying the "department" label to DCT is that it has now been decided that the Commissioner of Human Services (currently Jodi Harpstead) will continue to have a significant, although not controlling role in DCT by being a member of its executive board. This allows DCT to benefit from Ms. Harpstead's experience previously overseeing DCT's various units (including MSOP), while no longer saddling her with the burdensome workload of a hands-on daily role in DCT's administration. In this way, she can offer contributions toward setting and clarifying DCT policy, but won't dictate it.

Act 125 takes a new tack in expressly decreeing that consultation by DCT with

"Minnesota Tribal governments" as to DCT matters that "have Tribal implications. At least in the case of MSOP, the sizable representation of indigenous people among MSOP confinees strongly counsels the wisdom of this input. The foregoing provisions of the Act are already in effect, even though the full effective date of the DCT transitions will not be finalized until July 1, 2025. Notably, civilly committed persons who will be under the authority of Direct Care and Treatment on and after that date remain under the authority of the DHS until that date.

Other changes and significant repetitions enacted by either 2024 Act 79 or Act 125 are as excerpted below: Bracketed material are editorial comments. Underlined passages are added material. Struckthrough passages are repealed by Act 79. Passages in both bold and italic are simply emphasized by this editor.

Text Excerpts:

[Act 79:] "**ARTICLE I:**...

Section 4. [Summary: Minnesota Statutes (hereinafter, "Minn. Stat.") 2022, § 246.018, subdivision (hereinafter, "subd.") 1, establishes the Office of Executive Medical Director within DCT.]

Section 5. [Summary: Minn. Stat. 2022, § 246.018, subd. 2, directs the executive board to appoint a licensed physician certified by the Board of Psychiatry as a psychiatrist as executive medical director, who will assist in establishing and maintaining Direct Care and Treatment medical policies.]

Section 6. [Summary: Per Minn. Stat. 2022, § 246.018, subd. 3, duties of the executive medical director are:

- oversee the clinical provision of inpatient mental health services provided in the state's ***regional treatment centers***; (per Minn. Stat. §§ 246.23 and 252.41, subd. 7, MSOP is ***not*** a regional treatment center.);
- recruit and train psychiatrists to serve on the direct care and treatment medical staff;
- consult with the executive board, community mental health center directors, and the state-operated services governing body to develop standards for treatment and care of patients in state-operated service programs; (MSOP ***is*** a "state-operated service," per Minn., Stat. § 246.014 because MSOP is a "specialized inpatient" program (§§ 246C.02(a) & 253D.02, subdivision 13).)
- develop; and oversee a continuing education program for members of the medical staff; and
- participate and cooperate in the development and ***maintenance of a quality assurance program for state-operated services*** that assures that residents receive continuous quality inpatient, ***outpatient***, and postdischarge care. (This appears to provide post-release treatment at state expense to MSOP releases on provisional discharge, previously paid for by releasees themselves.

Section 7. Summary: Per Minn. Stats. 2022, § 246.018, subd. 4(a), the executive medical director shall establish a direct care and treatment medical staff under his/her clinical direction. Subdivision 4(b) commands that the executive medical director, in conjunction with the medical staff, must:

- establish standards and define qualifications for physicians who care for residents in state-operated services and monitor their performance; and
- recommend to the executive board changes in procedures for operating state-operated service facilities that are needed to improve the provision of medical care in those facilities. (In sum, Subdivision 4 effectively provides us, for the first time, with care and treatment by psychiatrists, as opposed to psychologists and social workers, and also provides us with at least general practice M.D.s for our physical health care. How thoroughly this will be implemented, however, remains to be seen, given the fierce cost of psychiatrists.)

...**Section 9**. Summary: Minn. Stat. 2022, § 246.12, requires legislative approval of closure of a state-operated facility if the executive board and respective bargaining units fail to arrive at a mutually agreed upon solution to transfer affected state employees to other state jobs. This does not apply to state-operated enterprise services such as MSOP's industry shops. (How this may interact with the provision below related to possible contracting out of MSOP does not appear to be specified, and may not be predictable.)

Section 10. Summary: Minn. Stat. 2022, § 246.14, allows the executive board to use available space in any institution under executive board jurisdiction or in any institution under the jurisdiction of another department or agency of the state offered by executive or legislative action to the executive board for the care and custody of persons, patients, or inmates of the institutions under exclusive control of the executive board for whom other, more suitable, space is not available. (As a crowding control measure, this may permit MSOP segments to be placed within other types of facilities, subject, of course to the need to keep security-confined populations together in such a facility.)

Section 11. Summary: Minn. Stat. 2022, § 246.234, authorizes the executive board, with the approval of the governor, to enter into reciprocal agreements with duly authorized authorities of another state or states regarding the mutual exchange, return, and transportation of persons with ***a mental illness or developmental disability***, who are within the confines of one state but have legal residence or legal settlement for the purposes of relief in another state. Any agreement entered into under this subdivision must not contain any provision that conflicts with any state law. (This does not appear applicable to us, since MSOP confinees are not considered to have a "mental illness." See: Minn. Stat. § 245.462 and *In the Matter of: Conelious McCaskill*, 603 N.W.2d 326; 1999 Minn LEXIS 843 (Minn. 1999), footnotes 4 & 7.)

...**Section 18**. Summary: Minn. Stat. 2022, § 246C.015 sets definitions applicable throughout Chapter 246C, excerpted here as of note to us:

Subd. 2. **Chief Executive Officer**. "Chief Executive Officer" means the ...Direct Care and Treatment chief executive officer appointed according to section 246C.08. [Doubtless, this will be Marshall E. Smith. Whether he can simultaneously serve as a member of the DCT Dept. Executive Board remains unclear. Until January 1, 2025, this will not be any conflict, since his appointment as CEO will apparently not take effect until then, however.]

Subd. 3. "Commissioner" means the commissioner of human services.

Subd. 4. "Community preparation services" means specialized inpatient or outpatient services operated outside of a secure environment but administered by a secure treatment facility.

Subd. 5. "County of financial responsibility" has the meaning given in section 256G.02.

Subd. 6. "Executive board" means the ... Direct Care and Treatment executive board established under section 246C.06.

Subd. 7. "Executive medical director" means the licensed physician serving as executive medical director in ...Direct Care and Treatment under section 246C.09.

Subd. 8. "Head of the facility" or "head of the program" means the person who is charged with overall responsibility for the professional program of care and treatment of the facility or program. This would appear to separately reference both the Clinical Director of each of MSOP's two facilities and the Executive Clinical Director of MSOP as a treatment program.

...Subd. 10. "Secure treatment facility" means a facility as defined in section 253B.02, subdivision 18a, **or 253D.02, subdivision 13**.....

Section 19. Summary: Minn. Stat., 2023 Supplement, § 246C.02, establishes ...Direct Care and Treatment, headed by an executive board (subd. 1); and specifies that the executive board shall provide direct care and treatment services in coordination with the commissioner of human services, counties, and other vendors (subd. 2); defines "direct care and treatment services" as "specialized inpatient programs at secure treatment facilities, community preparation services, regional treatment centers, enterprise services, consultative services, aftercare services, community-based services and programs, transition services, nursing home services, and other services consistent with the mission of ...Direct Care and Treatment".(subd. 3(a)); confirms that the commissioner of human services continues to constitute the "state agency" as defined by the Social Security Act of the United States and the laws of this state for all purposes relating to mental health and mental hygiene (subd. 5).

...**Section 21**. Summary: Minn. Stat., 2023 Supplement, § 246C.04, subd. 2 transfers custody of persons subject to civil commitment under chapter 253B or 253D and in the custody of the commissioner of human services to the executive board without any further act or proceeding. Authority and responsibility for the commitment of such persons is transferred to the executive board, and subd. 3 transfers the powers and duties vested in or imposed upon the commissioner of human services with reference to any state-operated service, program, or facility to the executive board according to this chapter.

Section 22. Summary: Minn. Stat., 2023 Supplement, section 246C.05(a), declares that personnel whose duties relate to the functions assigned to the executive board in section 246C.03 are transferred to ... Direct Care and Treatment effective 30 days after approval by the commissioner of management and budget; (b) provides that, before the executive board is appointed, personnel whose duties relate to the functions in this section may be transferred beginning July 1, 2024, with 30 days' notice from the commissioner of management and budget; and (c) provides the following protections employees who are transferred from the Department of Human Services to ...Direct Care and Treatment:

"(c)

1.No transferred employee shall have their employment status and job classification altered as a result of the transfer.

2.Transferred employees who were represented by an exclusive representative prior to the transfer shall continue to be represented by the same exclusive representative after the transfer.

3.The applicable collective bargaining agreements with exclusive representatives shall continue in full force and effect for such transferred employees after the transfer.

4.The state shall have the obligation to meet and negotiate with the exclusive representatives of the transferred employees about any proposed changes affecting or relating to the transferred employees' terms and conditions of employment to the extent such changes are not addressed in the applicable collective bargaining agreement.

5.When an employee in a temporary unclassified position is transferred to the ... Direct Care and Treatment, the total length of time that the employee has served in the appointment shall include all time served in the appointment at the transferring agency and the time served in the appointment at the ...Direct Care and Treatment. An employee in a temporary unclassified position who was hired by a transferring agency through an open competitive selection process in accordance with a policy enacted by Minnesota Management and Budget shall be considered to have been hired through such process after the transfer.

6.***In the event that the state transfers ownership or control of any of the facilities, services, or operations of Direct Care and Treatment to another entity, whether private or public, by subcontracting, sale, assignment, lease, or other transfer***, the state shall require as a written condition of such transfer of ownership or control the following provisions:

i.Employees who perform work in transferred facilities, services, or operations

(Continued on page 4)

must be offered employment with the entity acquiring ownership or control before the entity offers employment to any individual who was not employed by the transferring agency at the time of the transfer. [A right of first refusal.]

ii.The ***wage and benefit standards*** of such transferred employees ***must not be reduced*** by the entity acquiring ownership or control ***through the expiration of the collective bargaining agreement*** in effect at the time of the transfer ***or for a period of two years after the transfer, whichever is longer***. [Effectively, the contractor may act without restriction to such transferred employees as soon as two years after that transfer, assuming the current collective bargaining agreement has ended by then. More significantly, there is nothing in this provision that appears to prohibit a contractor from eliminating a position or eliminating many positions. The first-refusal provision applies only if a position exists. While it is an open question whether this 'elimination maneuver' can be carried out during the period set by the wage and benefits guarantee period, it is certainly clear that at its end, such position elimination is permissible (subject only to a continuing requirement to tender a position to anyone thus terminated when, at some later point, the contractor experiences an opening in a surviving or new position. This, of course, could be at any pay rate and benefits or lack thereof.)]

(d) There is no liability on the part of, and no cause of action arises against, the state of Minnesota or its officers or agents, for any action or inaction of any entity acquiring ownership or control of any facilities, services, or operations of ...Direct Care and Treatment. [This is the most contentious part of this Act. By this the State of Minnesota attempts to absolve itself from its responsibility for whatever happens to us after the State committed us and has kept us committed, including during any such privatized portion of such commitment, at the hands of employees of a contracting firm that the State has chosen to take the State's place in 'caring' for us and 'treating' us. The main question is whether this self-absolution can legally stand a challenge based on our constitutional rights. The standard answer would be: "Of course not." However, the authors of this provision, among legislative representatives, are brazenly defying the Constitution by this move, implying that they think no judge will follow the Constitution when it comes to our rights for political fear of losing their next re-election. This is not just an academic question, but instead is so serious in practical effect as, at worst, to be a life and death matter. In the five SOCC systems that have been privatized, the accounts of grievous abuse and even deprivation of the basics of life and health are legion. People have died because of the malfeasance and nonfeasance of such private contractor employees. More details on this in a later *tLP* edition. But it is not too early to start thinking about and discussing this matter of grave import at this time.]

(e) ***This section expires upon the completion of the transfer of duties to the executive board under this chapter. The commissioner of human services shall notify the revisor of statutes when the transfer of duties is complete.*** [Subsection (e) is new in Ch. 79. Its effect, especially as to Subsections (c)(6) and (d), is far from clear at this point.]

Section 23. [246C.06] EXECUTIVE BOARD; POWERS AND DUTIES. [THIS SECTION OF ACT EFFECTIVE JULY 1, 2024.]

Subdivision 1. **Establishment**. The executive board of ...Direct Care and Treatment is established.

Subdivision 2. **Membership of the executive board**. The executive board shall consist of no more than five members, all appointed by the governor. [From this provision, apparently no legislative confirmation/assent is required to finalize these appointments. Somewhat more earnest, however, is whether the sitting governor can remove without cause appointees of a previous governor. A related question is whether any official or governmental entity can challenge an appointment to this executive board for inadequate qualifications as established in Subdivision 3, immediately below, or is the appointing governor's decision final.]

Subdivision 3. **Qualifications of members.** An executive board member's qualifications must be appropriate for overseeing a complex behavioral health system, such as experience serving on a hospital or nonprofit board, serving as a public sector labor union representative, delivering behavioral health services or care coordination, or working as a licensed health care provider in an allied health profession or in health care administration.

Subdivision 4. **Accepting contributions or gifts.** (a) The executive board has the power and authority to accept on behalf of the state, contributions and gifts of money and personal property for the use and benefit of the residents of the public institutions under the executive board's control. All money and securities received must be deposited in the state treasury subject to the order of the executive board.

If the gift or contribution is designated by the donor for a certain institution or purpose, the executive board shall expend or use the money as nearly in accordance with the condition of the gift or contribution, compatible with the best interest of the individuals under the jurisdiction of the executive board and the state. [This, by type, is a 'Tammany Hall' "honest graft" provision. Its potential to bend and shape policy is real, but it is not illegal.]

Subdivision 5. **Federal aid or block grants.** (a) The executive board may comply with all conditions and requirements necessary to receive federal aid or block grants with respect to the establishment, constructions, maintenance, equipment, or operation of adequate facilities and services consistent with the mission of ...Direct Care and Treatment.... [Although not mentioned here, as to MSOP, the block grant provisions that are part of the Adam Walsh Act, the Jacob Wetterling Act, and allied federal legislation impacting sex offender commitment will potentially have a role in shaping the future of SOCC in Minnesota, if any. Some states have refused federal grant money that came with onerous strings as to sex offender requirements and restrictions.]

Section 24. [246C.10] FORENSIC SERVICES.

Subdivision 1. **Maintenance of forensic services**. (a) The executive board shall create and maintain forensic services programs.

(b) The executive board must provide forensic services in coordination with counties and other vendors.

(c) Forensic services must include specialized inpatient programs at secure treatment facilities, consultive services, aftercare services, community-based services and programs, transition services, nursing home services, or other services consistent with the mission of ...Direct Care and Treatment. [This provision appears to include MSOP, since forensic services: are defined to include services rendered to those committed as "Sexually Psychopathic Persons." See Minn., Stat. §§ 246.014(b) and 253D.02, subd. 11.]

(d) The executive board shall adopt rules to carry out the provision of this section and to govern the operation of the services and programs under the direct administrative authority of the executive board....

ARTICLE 5: CIVIL COMMITMENT...

Section 21. Minnesota Statutes 2022, section 253B.22, subdivision 1, is amended to read: [Note: Applicability to SPP/SDP confinees upheld in *Hince v. O'Keefe*, 632 NW2d 577; 2001 Minn LEXIS 481 (Minn. Supr. 2001).]

Subdivision 1. **Establishment**. The commissioner executive board shall establish a review board of three or more persons for the Anoka-Metro Regional Treatment Center, Minnesota Security Hospital, and ***Minnesota Sex Offender Program*** to ***review*** the admission and ***retention of patients*** of that program receiving services under this chapter. One member shall be qualified in the diagnosis of mental illness, developmental disability, or chemical dependency, and one member shall be an attorney.... [Note: Apparently, the *Hince* ruling of 2001, referenced *supra*, providing "like force and effect" of the "review board" provision not just to those mentally ill and dangerous, but also to those committed to MSOP, has never been revisited, and thus to date appears to remain valid precedential case law. The specific inclusion in Section 21 here gives a green light to those who wish to use such periodic review to seek a ruling that MSOP is not fulfilling its only valid mission under law and the Constitution: to efficiently treat and prepare for release, and then to release and, as needed, supervise releases and ultimately discharge their commitments. This attack is one alleging total institutional failure. Closure of MSOP would appear to be the only appropriate relief in this type of challenge.]

Section 22. Minnesota Statutes 2022, section 253B.22, subdivision 3, is amended to read:

Subdivision 3. **Notice**. The head of each program specified in subdivision 1 shall notify each patient at the time of admission by a simple written statement of the patient's right to appear before the review board and the next date when the review board will visit that program. A request to appear before the review board need not be in writing. Any employee of the program receiving a patient's request to appear before the review board shall notify the head of the program of the request. [See note to Subdivision 1, immediately *supra*. There is no restriction only to new/recent admits to MSOP.]

Section 23. Minnesota Statutes 2022, section 253B.22, subdivision 4, is amended to read:

Subdivision 4. **Review**. The review board shall review the admission and retention of patients at the program. The review board may examine the records of all patients admitted and may examine personally at its own instigation all patients who from the records or otherwise appear to justify reasonable doubt as to continued need of confinement in the program. The review board shall report its findings to the executive board and to the head of the program. The review board may also receive ***reports from patients***, interested persons, and employees of the program, and investigate conditions affecting the care of patients.

ARTICLE 7: MINNESOTA SEX OFFENDER PROGRAM....

Section 3. Minnesota Statutes 2022, section 246B.03, subdivision 1, is amended to read:

Subdivision 1. **Licensure** (a) The commissioner of human services executive board shall apply to the commissioner of health to license the secure treatment facilities operated by the Minnesota Sex Offender Program as supervised living facilities with applicable program licensing standards.

The executive board shall apply to the commissioner of human services to license the Minnesota Sex Offender Program as needed to provide program services. [Politically, a poor chance of success before the DHS commissioner.]

Section 5. Minnesota Statutes 2022, section 246B.04, is amended by adding a subdivision to read:

Subdivision 1a. **Program evaluation** The executive board shall establish an evaluation process to measure outcomes and behavioral changes as a result of treatment compared with incarceration without treatment to determine the value, if any, of treatment in protecting the public. [This process, once established, seems likely to present yet another opportunity to argue that MSOP has no relative effect toward protecting the public compared to imprisonment. Such a finding would be dynamite in a case claiming that MSOP commitment is just incarceration under a disguising rubric.]

(Continued on page 5)

ARTICLE 10: EFFECTIVE DATES, REPEALER, AND REVISOR INSTRUCTIONS....

Section 6. EFFECTIVE DATE. (a) Article I, section 23, is effective July 1, 2024.

Article I, sections 1 to 22 and 24 to 31, and articles 2 to 10 are effective January 1, 2025."

****

A "Baldrige" Award?: Possible Nomination of MSOP as a Whitewash of Its Problems?

by Cyrus Gladden

Will the Baldrige Award Process Be Misused to Whitewash MSOP in Order to Justify Its Continued Existence and Possibly to Increase Its Attractiveness for Privatization?

As noted in the companion article above about the 2024 legislative act modifying the 2023 law separating the former Direct Care and Treatment (DCT) Division from the Department of Human Services and establishing DCT as an independent agency of Minnesota government, nothing to date in either the 2023 or 2024 acts mentions possible closure of the Minnesota Sex Offender Program (MSOP, now a division within the DCT agency).

As other articles in *the Legal Pad*, both past and ongoing, show, MSOP does not have a true valid purpose to expeditiously treat and release those committed to it, but rather is simply a covert device to subject its confinees to indefinite supplementary incarceration for as long as can possibly be defended. It does this through misapplication of assessment and inaccurate treatment documentation, along with other means.

The motive for all these unethical actions is to cast false appearances of an unremitting need for "change" of sexual orientation (which inherently is never possible to change), of claimed (but typically nonexistent) resistance by confinees of progress through therapy, and of a conclusory assertion of continued "danger of re-offense," either by choice of any given confinee or his claimed treatment failure.

MSOP justifies maximum confinement by applying a unique treatment regimen based on a highly elaborate "Matrix" of 32 factors that every treatment-participating confinee must satisfy and demonstrate thereafter constant ongoing mindful application of in order to qualify for treatment 'completion' and MSOP assent to release, even just to the highly supervised state known as "provisional discharge."

Yet MSOP has only rarely conceded that anyone has ever fulfilled this ongoing standard. Instead, lack of measuring up to this Sisyphean standard is used to justify delay of release for decades, often until death in confinement. This is true even for those who did not die in that status until they were age 80 or 90 or even older. In the 30 years that MSOP has existed, during which 103 confinees died in confinement, and with a current confinee population of about 750, only about 64 are now on provisional discharge, and only 24 have been granted final discharge from their commitments.

Further, the panel of judges who decide to grant or deny provisional or final discharge make their decisions on an underlying biased belief at odds with science that, simply due to the commitment of such confinees, they are far more likely to sexually reoffend than the cohort of sex offenders (recidivists included) released from prison in the same years of their selection for commitment, on mostly purely demographic and in any event, unscientific, impressionistic factors that often include discrimination on same-gender orientation and race.

In other words, the whole system of sex offender commitment, including the decisions to keep confinees committed, in concert with the anti-scientific and usually counterfactual practices of MSOP, do not represent a system in a state of failure, but rather, a system amorally bad by design and consistent practice *ab initio*, to seize upon certain sex offenders to vilify in order to cast a continued false image of 'crazy monsters' who cannot be allowed to be at liberty among the populace.

\- - - - - - - - - - - - - - -

Also as stated in that companion article, rather than provide any means for MSOP closure, the Legislature has written into both its 2023 act and its 2024 act dealing with DCT's transition into being a separate agency express authorization for DCT to contract with one or more private contractors to take over operation of some part(s) or all of any DCT division. This includes MSOP. There are apparently a half-dozen competitors who seek to contract to undertake operation of sex offender civil commitment systems or at least one facility of such a system, or at least the treatment part of such system operations.

\- - - - - - - - - - - - - - -

Whether as a basis for resisting arguments for closure of MSOP or to make MSOP a more tempting target for private contractors to pursue, a favorable evaluation of MSOP's operations would be of substantial assistance. As it happens, correspondence sent by the office of the head executive of the DCT to a nongovernmental entity included a cryptic handwritten name, "Baldrige," on a self-adhesive note attached to a document in that mailing about MSOP. After considerable investigation, this writer has determined what Baldrige is and what its potential role could be in this controversy about MSOP's future, if any. This article explains that potential role in what would most likely be a deft whitewash to cast an appearance of an efficiently functioning government agency performing a societally needed service. Nothing could be further from the truth, but what follows will explain how that false appearance might be cast.

First, it is necessary to gain an understanding of what Baldrige is. President Ronald Reagan observed increased international competition for business of all kinds that was eroding the business and economic supremacy up to that time. In an effort to lessen such erosion, the Reagan Administration urged Congress to establish a means to foster greater productivity, quality of goods produced, and efficiency of operations, together with other optimizing aspects, such that sales, revenues, and profitability of American businesses could be increased. This was to be accomplished by creating an awards program sponsored by the federal government. Congress established this program through Public Law 100-107, the Malcolm Baldrige National Quality Improvement Act (named in honor of a recently then-deceased Secretary of Commerce of that era). Effectively, this Award Program was to identify and recognize role-model businesses, and thereby to provide criteria for other businesses for evaluating their improvement efforts.

At first, program operation was conducted by a government agency. During that period, the Secretary of Commerce was authorized to accept private donations to operate the program. Eventually, the Baldrige Foundation (a private non-profit entity) was established to raise and manage such private donations to fund the operation of the judging and awards program. In 1998, President Bill Clinton expanded the business categories to include, among other areas, health care. At that time, federal appropriations began for the purpose of more fully funding the program, but budgetary pressures ended federal funding in 2011. Since then, all funding has been private. It would seem probable that such funding sources, at least indirectly, have come from the businesses and other entities seeking such awards.

Now called the Baldrige Performance Excellence Program (Baldrige Program or simply "Baldrige" for short), the Baldrige Program focuses on:

- Performance excellence
- Organizational assessment tools and the Malcolm Baldrige National Quality Award® (for short, Baldrige Award) based on long-term organizational success
- Competitive advantage and success in the particular class of entity of the award applicant
- Baldrige-based approaches focused on quality jobs, cybersecurity risk management, leadership development, and community excellence

Approximately 1400 award applicants are independent state-level 501(c)(3) nonprofits, along with some universities and state and local government agencies. These are handled by the Baldrige Enterprise, a Baldrige subsidiary formed when federal funding ended. It is not clear to this writer yet whether Baldrige Enterprise is profit-making or, if nonprofit, whether any surplus reserves that may be amassed through Baldrige Enterprise operations are solely used to subsidize its further operations, or whether some portion may be allocated to executive compensation and perquisites. The Baldrige Award apparently does not involve any cash prize; the award is strictly an honor.

Showing its focus on criteria that are business-success factors, judging includes the following aspects: increases in number of operation sites for an applicant organization, median growth in revenue, and median growth in jobs, matched against similar entities in matching time periods. Apparently, the closest type of organization that has sought the Baldrige Award is that of profit-based hospitals. Winners in this class have been judged on higher profit margins and lower mortality rates, as well as general "higher improvement levels." The Baldrige Program acknowledges that "organizations don't receive the award for specific products or services." Consequently it is difficult to see what relevance the Baldrige Award, even if won by MSOP, could have to MSOP's treatment program or other practices concerning, for example, release of confinees.

The preceding article addressing 2024 Minnesota legislative Act 125 restructuring DCT authorizes, at Article 5, Section 13, subdivision 5, a nonprofit organization acting as a "professional standards review organization established pursuant to United States Code, title 42, section 1320c-1 et seq. ...to gather and review information relating to the care and treatment of patients for the purposes of: (a) evaluating and improving the quality of health care; ... (e) developing and publishing guidelines designed to keep within reasonable bounds the cost of health care; ...(m) providing recommendations on the medical necessity of a health service, or the relevant prevailing community standard for a health service; (p) providing information to other ... review organizations, when that information was originally generated within the review organization for a purpose of a review organization as specified by this subdivision...."

Given Baldrige's history of evaluating programs in hospitals, it would seem that it can fit this operational description sufficiently to qualify as a reviewer of any of the units within DCT, including MSOP. It is completely plausible that this unique provision finds place in Act 125 in contemplation of just such use of Baldrige as to MSOP.

While award recipients must share information about their exceptional performance practices with other U.S. organizations, they don't need to share proprietary information, even if it was in their award application or submitted in connection with it. Even the identity of award applicants is kept secret if they do not win the award. Therefore, simply applying for the award, even if hopeless for a failing organization, can then be trumpeted publicly by that organization for a false implication that it is not just doing well, but excelling at what it does, all with no means by the public to check with Baldrige on such submissions.

If an application for the Baldrige award were to be submitted by MSOP or by DCT, as its administrative parent, either on MSOP's behalf or as part of an overall application for DCT altogether, the implication from the fact of that submission would appear to be fraudulent, or in any event false in substance. If done in the context of the present controversy about MSOP, it

(Continued on page 6)

would appear to be to manufacture an invalid argument for MSOP's continued existence and operation in its status quo.

Either in conjunction with such an argument or separately (as has been questioned above), submission of such an application could be used to cast an impression of successful operation of MSOP in order to impress potential private contractor suitors for a contract with DCT to take over MSOP operation, with or without concurrent acquisition of the improved real estate of MSOP's Moose Lake facility. Matters of the possible motivations to privatize MSOP operation are discussed in the companion article addressing the 2024 legislative modifications to DCT elevation to separate agency status.

Source: www.nist.gov/baldrige/how-baldrige-works/about-baldrige.

****

A Tale of Three SOCC Facilities Run by Private Contractors

By Cyrus Gladden

1. Rushville, IL

The current trend toward privately operated systems and facilities of sex offender civil commitment (SOCC), if left unchecked, sooner or later will cause all SOCC systems, including MSOP, will be as tightly constrained as the near-solitary confinement routines of the Rushville Treatment and Detention Facility, at Rushville, Illinois. At the very least, those routines approximate high-security jail operations, where prisoners never leave their residential "pod" except for official summons and specifically authorized and escorted activities. Rooms housing those committed to Rushville are about 9 feet by 9 feet, smaller than those in MSOP-Moose Lake. To make this cramped space work, the outer wall of each room is occupied by an over-and-under bunk bed. A 6-inch high, four foot window supplies daylight to the cell, but is covered with a frosted surface preventing even the slightest view outside. The only other furnishings are the toilet/sink unit, plus a small table serving as a writing desk, with a single molded plastic chair. A photo sent to me showed a cardboard box supporting a 13" TV set.

According to a detailed report by the *Civil Commitment Working Group Illinois*, "Inside Illinois Civil Commitment: 'Treatment Behind Razor Wire'," https://insideciviilcomil.com (Chicago and Rushville, IL, 2022), commitment to Rushville is effectively a supplemental life sentence, on top of the prison terms that Rushville confinees already served. Only an extremely small trickle of Rushville confinees are ever released. The overall conditions of Rushville confinement are extremely austere and punitive.

The aforementioned report recommended that the Rushville commitment system release people at higher rates and create a transparent and accessible pathway for confinees to access conditional release. It also recommended that confinees be allowed "expanded" access to the outside world. However, without any internet access, now, Rushville confinees effectively have no meaningful access at all to the world outside. Rushville confinees have only infrequent individual private meetings with their therapists. Hence, the report also recommended that Rushville confinees get more one-on-one, confidential therapy. To date, none of the recommendations in that report have been provided.

...Though receiving treatment is technically voluntary, people at Rushville are not allowed to be released unless they finish their treatment, making this a coercive practice where they must receive treatment or stay in Rushville for life.

However, residents at Rushville find it impossible to be released even when agreeing to and spending years in treatment. Further, treatment at Rushville relies on outdated and cruel practices that are under-researched and unsupported by research. ...Residents get shuffled between providers due to the high turnover of therapists. These practices make it incredibly difficult to move forward in treatment and get released.

But research does not show that these tools work (Hoppe, Meyer, De Orio, Vogler, & Armstrong, 2020). None of these tools (or risk assessment tools in general) support Rushville residents' healing, treatment, or progress, and thus, none of these tools make communities safer. The data gathered from these tools often end up harming residents' chances at release in court. No equation can predict a given individual's behavior, and data about the past behavior of a group of people cannot predict the future behavior of any specific individual.

Regulation and Evaluation Tools at Rushville

Rushville uses the following tools to measure treatment progress and control residents' behavior. Many of these measures rely on risk assessment data, or data that draws correlation between an individual's characteristics and their behavior. Behavioral risk assessment measures rely on the false pretense that human behavior can be predicted. These tools raise a host of ethical red flags, as they use generalized statistics to make decisions about individuals' freedoms. Instead of imposing retroactive consequences for individuals' historic behaviors, risk assessment tools justify punishing individuals for their 'risk' of committing behaviors that have not already occurred. These tools are punitive, not rehabilitative.

Residents at Rushville have criticized the following tools. The use of the penile plethysmograph (PPG) is humiliating and the images and sounds shown to them during the exam are perceived as disturbing. Critics debate both the efficacy and morality of the PPG. Further, the guidelines for administration of the PPG are vague and variable The use of a polygraph creates a culture of distrust that is a barrier to cultivating a healing treatment environment. Polygraphs and PPGs will ultimately become important in determining an offender's progression through treatment, risk level, and potential for release (Vogler, 2021, p. 126). When residents raise such concerns, question the accuracy of these measures, and refuse to take polygraph tests or PPG exams, they are punished further.

Chemical castration is when an individual is prescribed drugs to alter their hormonal chemistry. At Rushville, chemical castration includes administering anti-androgens such as Leuprolide and Eligard as well as Estrogen (Estradiol, a female birth control hormonal medication). The hormonal therapy used for chemical castration can have major side effects that impact both physical and mental health such as bone density loss, infertility, and depression. The ethics of chemical castration are highly contested, and many critics question the legality of allowing the state to alter a person's body.

Rushville is a violent place with poor living conditions. Survey respondents reported receiving poor quality and insufficient healthcare. Facility staff insist on using handcuffs, including 'black box' handcuffs that can cause permanent wrist damage, on residents who are brought to hospitals. Insufficient medical care is an urgent issue at Rushville, especially given the long-term nature of detainment and the aging population.

Between 2006 and 2020, more people at Rushville died than were discharged.

According to a response to the Freedom of Information Act request that In These Times reporter Sarah Lazare made in the summer of 2020, 76 people died in custody at Rushville since the facility opened in 2006. During the same period only 30 people were discharged from the facility (Lazare, 2020).

...People at Rushville have been there, on average, for nearly a decade and counting.

At the time of the survey, the length of residents' detention at Rushville ranged from 6 months to 21 years, and the average amount of time people had been at Rushville so far was 9 and ½ years. Indefinite detention with infrequent releases has led many residents to feel that they have received a death sentence.

Rushville's practices exacerbate our culture of sexual harm through forced treatment, recounting traumatic experiences, forced confinement, and experiencing the lack of bodily autonomy that comes with all forms of detention. We see similarities in our experiences and stand against Rushville's practices, declaring that none of us can be free of sexual harm until we are all free of sexual harm.

The aforesaid report ended with this Conclusion: "*Rushville Treatment and Detention Facility must close.* Rushville does not make us safer. ...Rushville does not 'cure' people, it cannot prevent harms that have not occurred, it cannot heal trauma or harm. ...Rushville is not a treatment center, it is a prison full of people who are serving de facto life sentences."

****

2. Columbia, SC

Editor's Note: South Carolina's SOCC confinement facility is operated by a private contractor, Wellpath. The following excerpt from accounts there is provided by one of those confined there.

Todd Maschino, Personal Correspondence, August 8, 2023

Text Excerpts:

"As for Wellpath and its obligation to us, this is a joke to say the least. Even though Wellpath is paid to provide for our needs, we are being milked for everything. Example: clothes. If there's money in your account or you have family it's your responsibility. Wellpath only provides two pair of fleece sweat pants and long-sleeve shirts, cotton T-shirts that shrink when washed, and prison-style briefs. For those without an income or family., our chaplain has gone to a local church for aid.

For food, we were told to supplement with purchases from Keefe or Walkenhorst's (our only vendors presently). Our quantity of provided food has gone down even more so since Wellpath came. All we're told is to "use your coping skills." In my opinion they don't belong here....

Memos change so fast here we are dizzy. ...I was approached by my casemanager and informed that there were three editions of legal magazines that I could either approve to be put in the shred bin for destruction or I could send them home. These were *Criminal Legal News* and *Prison Legal News*. All I was told was that they contained "questionable content." I normally receive these publications in our regular mail without question. This tells me that there is/are article(s) which are negative to Wellpath. These editions were referred to an administrative assistant here two was our paralegal when this facility was run by the Department of Mental Health itself. Now this person does nothing under Wellpath direction but administrative matters such as coordinating legal calls, court dates and times, and visitation."

****

3. Littlefield, TX

For many men serving time for committing sex offenses in Texas, their prison time never really ends – even if they complete their sentence. ...That facility, known as the "TCCC" – in Littlefield, Texas – is actually a former maximum security prison in the middle of a dirt field.

Of course, Molnar notes, if the state really 'wanted them to have treatment and counseling, they had plenty of time to get that done. In some cases, the men served 20 to 25 years' in an ordinary prison before being civilly committed. Civil commitment is an extra prison sentence by another name.

Originally called *clients* or *residents* when the center opened in 2015, the men have been re-labeled 'inmates' since Manage-

(Continued on page 7)

ment and Training Corporation [MTC], a private prison company, took over in 2019.

When an inmate moves up a tier in treatment, he can find himself demoted for many reasons, including very small infractions. One man who had been at Littlefield for years and made it through all four tiers was finally about to get his release hearing. But he did something wrong – rumor had it he swore at a guard – and was knocked back down to Tier 1, where he would have to start anew, according to Murphy. He went to his cell and hanged himself.

A former Littlefield guard I'll call Frank – who says he quit but wants to stay in corrections and fears retaliation – said this wasn't the only tragedy he has witnessed there. Another man, he said, castrated himself.

Frank estimates about 15 percent of the men are intellectually challenged, so they will never be able to successfully complete the therapy, because they don't understand it.

The men must keep masturbation diaries, wear ankle monitors, and even use penile circumference gauges.

One confinee there exclaimed, "There will never be a treat-and-release model, a clear path out or justice done by it. It is nothing more than a collateral life sentence for those of us in it. ...It is what it is!!!"

Until recently, inmates also had to pay a 33 percent tax on any packages they got, further isolating them from any support system they might have on the outside. For instance, if family members sent a pair of jeans and three boxes of Chips Ahoy, they would have to document what it cost and pay another 33 percent to the TCCC shadow prison.

'One of our members during Covid-19 sent her son a package of masks and they were valued at $20,' says Molnar. 'She had to pay 33 percent on top of that to send him those masks.'

That rule was just changed. Now prisoners have to pay a 25 percent fee on any money sent to them from someone other than their spouse, according to Molnar.

...Littlefield has become a human 'storage facility,' says Frank. One confinee described the deliberate-overcrowding housing approaches by MTC thus:

"First, they wanted to house TCCC residents in a non-climate-controlled gym [in Texas!], with only 1 toilet, 1 urinal, and kind-of-a-shower. This arrangement would not have met the minimum standards of the 8th Amendment for non-disciplinary housing of mental health clients – This, after our in-dorm recreation area was taken from us, to put way too many ...bunk beds in them, which does not meet the contemporary standards of decency for 'treatment center client housing.'

Now, MTC wants to convert the canned goods and dry goods food storage room, with no toilet, no urinal, no outside light source, inadequate ventilation and no shower, into 'housing,' for up to 12 bunks. This cannot be in compliance with the contract requirements that MTC signed with the State of Texas to provide adequate and industry-standard/appropriate housing, treatment, medical care and food service to the approximately 400 TCCC human beings that MTC is trying to squish in here like sardines...."

It seems quite clear that the State of Texas simply allows MTC to do whatever they wish, no matter how inhumane.

The average age of inmates is 58, says Murphy. 'But there are several 80-year-old men. There are several blind men, several that use walkers and wheelchairs.' That's because almost no one ever manages to complete the therapy, according to a 2015 study.

During the height of the Covid-19 pandemic, when the men were locked two to a cell for 23 hours a day for several months, nine men out of about 300 died.

'We were to go with them to the hospital, two officers per resident – and you would just stare at them while on ventilators and get paid for it," says Harner. "And when they knew they were dying, they weren't even allowed to call their mom or dad...."

One confinee at the TCCC was denied his cancer medication because it cost too much. Apparently, the private contractor operating that Littlefield facility felt that this cost would eat into its annual profits. Several times this confinee tried to get the medication that he needed to fight his cancer but was denied. This ultimately led to his life being cut short.

A little over two years ago, another Littlefield confinee collapsed from a massive heart attack and died on the sidewalk on the way to the facility's medical office. Mr. Hoyt had been complaining to medical staff for several days about not feeling good. On each occasion of these complaints, he was sent back to his dorm with medical doing nothing, even simply to attempt to discover the cause. This last time, he did not make it to the medical office to be denied again. "Escorting security staff persons forced him to walk to the medical office, located in a building distant from his residential building despite obvious signs of an ongoing heart attack. When he collapsed to the ground in his last minute or so of life, those staff persons shouted at him to get up and kicked him as he lapsed unconscious and died. When the staff loaded his now-lifeless body onto a gurney (which had been available to use to convey him to the medical office, but security staff declined to request to use it then), many of the staff were laughing. Mr. Hoyt was a tiny man, no more than 5'6" and maybe 125 lbs., wet. They laughed at how they manhandled his body and later his corpse. They found this greatly funny.

Medical Services in the Littlefield facility are now directed by MTC. So they are looking at ways to deny medicine and medical treatment to their confinees. MTC's motto is BIONIC –'Believe It Or Not, I Can!' What the confinees there find most believable is that "Believe It Or Not, I Can!" actually is a private self-satisfied assurance that, in mistreating their detainees/"Residents," TCCC administrators and staff have unbridled carte blanche and will never be held accountable in the slightest – even when the subjects of their mistreatment and malignant neglect are killed as a result.

If MTC admnistrators are concerned so much about costs, it is bitterly ironic that they are able to host parties for the staff at the expense of life-and-death medicines they refuse to buy. Often they have BBQs for the staff, or some type of meal, give away sodas and popcorn, while "Residents" die due to medical cost "concerns." Approximately two weeks after that heart attack victim died, MTC had a fish fry with mini-golf for the staff -- while budget cuts reduced the "Resident's" food and medical care and medicines. At the same time, the Director of the state agency charged with oversight of MTC performance, asked for (and got) a pay raise. It seems ironic that such misconduct, which would have been condemned and banned in the times of Charles Dickens in Old England, runs in the USA of modern times as unobstructed as a runaway train engineered by madmen, with all responsible for it simply turning a blind eye and having another BBQ and beer.

The Future of 'Pre-Crime' Permanent Detention?

****

"Special Measures":

SOCC Is Not Needed, Is Pointlessly Punitive & Unhelpful.

Michael O'Hear, "Managing the Risk of Violent Recidivism: Lessons from Legal Responses to Sexual Offenses," 100(1) *Boston University Law Rev.* 133 (January 2020)

Text Excerpts:

[p. 139:] "While scholars have paid little heed to the system of special measures that has emerged to deal with *violent recidivism* ['VR'], they have devoted a great deal of attention to the somewhat overlapping control regime for *sexual recidivism* ('SR').[24] The heightened attention follows, no doubt, from legislatures' increased boldness in designing special measures for sexual offenders, including such headline-grabbing, constitutionally suspect innovations as sexual offender registration and notification ('SORN') laws[25] and sexually violent predator ('SVP') laws that authorize indefinite civil commitment,[26] residency restrictions,[27] and even chemical castration.[28] In general, scholars have been quite critical of such innovations both on fairness and efficacy grounds.[29]....

[pp. 145-46:] ...[R]esearch provides a more complicated and perhaps somewhat less terrifying picture of sexual offenders than is suggested by popular mythology:

- Sexual offenders do not have especially high recidivism rates compared with other offenders.[60]
- When they do reoffend, the new crime is only rarely sexual.[61]
- The great majority of sexual offenses are committed by individuals who have no prior conviction for a sexual offense.[62]
- The great majority of sexual offenses are committed by a person who was known to the victim, not a predatory stranger.[63]
- As with other types of offenders, the recidivism risk of sexual offenders tends to diminish with age.[64]
- Sexual offenders individually determined to be low risk are no more likely than other offenders to commit a sexual offense after release from incarceration.[65]
- Within about eight to thirteen years after release, even those sexual offenders individually determined to present mid-level risks are no more likely than other offenders to commit a sexual offense.[66]

[pp. 148-49:]1. Entrance Decisions ...[T]hese scientific aspects of RA are considered within a legal decision-making process that leaves much room for discretion, politics, and subjective value judgments. In the end, for civil commitment, it is a lay jury or judge that determines whether the requisite dangerousness threshold is met. Although states vary in how precisely the legal standard is defined,[79] in most states civil commitment turns on whether the offender is 'likely' to reoffend sexually, with no particular probability specified.[80] In such states, judges and jurors are essentially free to decide on a case-by-case basis 'how safe is safe,' creating a possibility that highly risk-averse decision-makers might order the confinement of offenders whose likelihood of re-offense is relatively low.

A study of jurors in Texas highlights the difficulties of unclear standards. The researchers submitted questionnaires to individuals who actually served on civil-commitment juries in 2009 and 2010 in order to ascertain their interpretation of Texas' civil-commitment standard -- 'likely to engage in a predatory act of sexual violence.'[81] More than 90% of the jurors returned their questionnaires, with the majority indicating that even very low recidivism risks would satisfy the legal standard.[82] For instance, nearly 54% of the jurors said that even a 1% chance of recidivism would be sufficient to support indefinite civil commitment.... However, if most jurors find most sexual offenders eligible for civil commitment, the civil-commitment laws no longer serve their original purpose of intervening with only the most high-risk offenders.'[85]

[pp. 150-51:] 2. Exit Decisions ...Simply put, once in, it has proven extremely difficult in many states for individuals ever to get out.

Civil commitment is nominally intended to provide treatment to the confined sexual offenders and return them to the community as soon as it is safe to do so.[96]...

(Continued on page 8)

Yet in practice, many states have returned very few civilly committed individuals to the community.[99] For instance over the first two decades of Minnesota's SVP law, the state did not permit any of the 700 committed individuals to return home – even though more than thirty of them were in their seventies or older.[100] Similarly, over the first fifteen years of the program, Missouri released only seven of 250 committed individuals.[101]

[pp. 151-2:] Such figures do not seem consistent with the ideal of individualized, risk-based decision making, which should account for changes in an individual's risk. In particular, sexual-offender risk normally decreases with age.[102] Overall, it has been estimated that a person's risk of sexual re-offense can be expected to drop by about 2% each year after age 40.[103] These aging dynamics are especially important to bear in mind in the present context since those who are in civil commitment tend to be an older offender group – after all, they are normally not considered for this status until they have reached the end of a prison term that was imposed for a serious offense.[104] Thus, taking age into account, we might expect that many civilly committed individuals would 'graduate' from the highest risk categories within a few years of admission. Yet release from confinement remains an elusive goal for most. Whatever the data reveal about an individual's actual likelihood of re-offense, the political dynamics are such that decision-makers tend to be quite risk averse when it comes to returning to the community a person bearing the 'sexual predator' label that typically accompanies civil commitment.[105]

3. Warehousing Ideally, a civil-commitment program that aims for rehabilitation and reintegration would deliver individualized treatment to offenders in the least restrictive possible setting. In practice, however, civil commitment often means little more than simple warehousing. The criticisms focus on two overlapping concerns: (1) poor design and administration of treatment; and (2) a dearth of community-based alternatives to full-time institutionalization.

[pp. 153-4:] While there are grounds for optimism regarding the *potential* of treatment, the actual rehabilitative efforts of civil-commitment programs have been subject to substantial criticism. For instance, consider the program in Minnesota, which has the nation's highest per-capita rate of civil commitment.[111] In a 2015 ruling on the program's constitutionality, a federal district judge found the following:

- 'The evidence clearly establishes that hopelessness pervades the environment at the Minnesota Sex Offender Program (the 'MSOP') and that there is an emotional climate of despair among the facilities' residents....'[112]
- 'Virtually every offender enters the treatment program' at the same phase, without regard to the offender's individually determined needs.[113]
- The criteria used to determine whether an offender is ready to progress to the next phase of treatment are applied inconsistently by MSOP clinicians.[114]
- 'The lack of clear guidelines for treatment completion or projected time lines for phase progression impedes a committed individual's motivation to participate in treatment for purposes of reintegration into the community.'[115]
- Clinical staffing shortages and turnover at the MSOP have hindered the ability of the MSOP to provide treatment as designed and have impeded treatment progression of committed individuals at the MSOP.'[116]

[p. 154:] Deficiencies in the Minnesota program reflect, at least to some extent, a more fundamental and generalized ambiguity in the role of civil–commitment treatment providers. One group of critics has characterized the problem this way:

> The staff ...are often confused about their role. Is it their job to make an honest attempt to treat these individuals in the most effective way possible, thus enhancing their chances of release? Or alternatively, is it their first responsibility to help ensure that their charges continue to remain committed as SVPs? ...Are therapists clinical babysitters hired to dress up the program or are they functional change agents?[117]

Another impediment to effective rehabilitation has been the overwhelming reliance of most programs on full-time institutionalization.[118] The research on sexual-offender treatment has found better outcomes with community-based (outpatient) treatment than prison-based (inpatient) treatment.[119] This is not surprising. 'Effective treatment not only requires that participants acquire a number of skills by which to manage their sexual deviance but also that they be given the opportunity to practice these skills in realistic situations.'[120] The artificial social environment of the institution is hardly conducive to realistic practice and may, in fact, function in counterproductive ways by surrounding the offender with potentially negative influences (i.e., the other offenders in the program). Time in the community provides better opportunities for developing and strengthening positive social relationships.

There are, to be sure, legitimate public-safety concerns regarding the release of high-risk offenders into the community. If we assume that civil-commitment programs are doing a good job of targeting those offenders who, at least at the outset, actually do present unusually high recidivism risks, then conventional, loosely supervised parole-type release will generally not be appropriate. However, there are a range of intermediate options between conventional parole and continuous, full-time institutionalization – options that might plausibly permit the attainment of some of the benefits of community-based supervision and treatment.

[p. 155:] The three basic 'intermediate' models are the halfway house, home detention, and intensive supervision. The halfway house is a community-based institution in which offenders are required to reside but which permits a certain amount of coming and going, for instance, to an approved place of employment.[121] Home detention provides greater freedom as to place of residence but restricts movement outside the home to certain approved places and hours.[122] Intensive supervision is more akin to conventional parole, but agents keep closer tabs on the offender, for instance, through more frequent home visits or drug tests.[123]

[p. 156:] In principle, community-based civil commitment could be implemented either as a transitional step after institutionalization or as an initial placement. In practice, however, some states preclude a community-based initial placement and require a period of full-time institutionalization after civil commitment has been ordered.[129] This seems an unnecessary and ill-advised limitation. The ideal of individualized treatment, coupled with the research indicating that the prospects for rehabilitative success tend to be higher with community-based interventions, suggest that intermediate options should at least be available for consideration even when civil commitment is first ordered.

[pp. 156-57:] The voluminous research and critical commentary on SORN and SVP civil commitment suggest a number of lessons regarding the management of residual recidivism risk:

- The fact that a person has been convicted of a particular offense at some point in time does not ...reliably indicate that the person is likely to commit other offenses in the future....
- Since risk tends to diminish with age, lifetime or very long-term control measures are normally unwarranted.[132]...
- ...[T]here is no purely scientific answer to the fundamental question of 'how safe is safe?'; without clear, rigorous standards in the law, lay jurors and politically accountable decision-makers are apt to be quite risk averse and may choose to impose control measures on individuals who do not present especially high levels of risk.[135]...
- Treatment is more likely to be effective if administered in a community-based setting than in a prison-type setting.[139]...

IV. IMPLEMENTING THE INDIVIDUALIZED APPROACH

Guiding Principles

3. If the Residual-Risk Standard Is Satisfied, Special Measures Should Be Individualized and No More Restrictive than Necessary; There Should Be a Presumption Against Full-Time Institutional Confinement as a Special Measure.

[p. 184:] As discussed above, one of the major criticisms of SVP civil commitment has been its overreliance on full-time institutional confinement as a one-size-fits-all response to the threat of sexual recidivism.[252] Other methods of structuring supervision, such as intermittent confinement in a halfway house or home detention with GPS monitoring, offer better rehabilitative prospects and – as lesser deprivations of liberty – may reduce the inherent tension between special measures and the proportionality ideal.[253]

[p. 186:] 4. The Duration of Special Measures Should Be Strictly Limited.

Another recurring criticism of SVP civil commitment has been that very few individuals ever 'graduate' from full-time institutionalization into a lesser (or no) form of commitment, even though risk normally diminishes with age.[262] This harsh reality can create a sense of hopelessness among inmates[263] and diminish their motivation to participate in treatment,[264] among other problems.

SVP statutes do provide for regular review of civilly committed individuals[265] and a process by which they can petition for release from institutionalization or discharge from commitment entirely.[266] ...However, based on the SVP experience, these safeguards may not be sufficient to ensure that measures are reliably eased when they are no longer necessary."

Notes:

24 These sets of laws overlap because some sexual offenses, such as rape, are also often regarded as violent offenses.

25 See *infra*, Section I.A.

26 See *infra*, Section I.B.

27 *Michael O'Hear*, Prisons and Punishment in America: Examining the Facts 151-52 (2018) (doubting that residence restrictions are effective based on existing research).

28 *Michael Petrunik, Lisa Murphy & J. Paul Federoff*, "American and Canadian Approaches to Sex Offenders: A Study of the Politics of Dangerousness," 21 *Fed. Sent'g Rep.* 111, 115 (2008).

29 See, e.g., *J.J. Prescott*, "Portmanteau Ascendant: Post-Release Regulations and Sex Offender Recidivism," 48 *Conn. L. Rev.* 1035, 1040 (2016) (noting "scholarly consensus" on ineffectiveness of SORN laws).

60 See *Matthew R. Durose, Alexia D. Cooper & Howard N. Snyder, U.S. DOJ*, Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010 — Supplemental Tables: Most Serious Commitment Offense and Types of Post-Release Arrest Charges of Prisoners Released in 30 States in 2005, at 3 tbl. 2 (2016), https://www.bjs.gov/content/pub/pdf/rprts05p0510_st.pdf [https://perma.cc/3AEB-4AD9] (showing that 60.1% of inmates released from prison in 2005 for sexual assault sentences were rearrested within five years; figures for property and drug offenders were 82.1% and 76.9%, respectively).

61 See *id.* (showing that only 5.6% of inmates released from prison in 2005 for sexual assault sentences were rearrested for sexual assault within five years; 51.4% were rearrested for public order offenses, 17.9% for property offenses, and 13.0% for drug offenses). A more recent nine year follow-up report found similar patterns. See *Mariel Alper & Matthew R. Durose*, Recidivism of Sex Offenders Released from State Prison: A 9-Year Follow-Up (2005-14), at 4 tbl. 2 (2019), https://www.bjs.gove/content/pub/pdf/rsorspyfu0514.pdf [http://per,ma.cc/V6CG-JAFF] (showing that only 7.7% of inmates released from prison in 2005 for

(Continued on page 9)

sexual assault sentences were rearrested for sexual assault within nine years; 58.9% we rearrested for public order offenses, 24.2% for property offenses, and 18.5% for drug offenses).

62 See, e.g., *Jeff A. Bouffard & LaQuana N. Askew*, "Time-Series Analyses of the Impact of Sex Offender Registration and Notification Law Implementation and Subsequent Modifications on Rates of Sexual Offenses," 65 *Crime & Delinq.*, 1483, at 1504 (2019) ("Our results also show that as many as 70% of the sexual offenses [in Harris County, Texas] were committed by individuals who had not previously been arrested for [a sexual offense], at least in this particular jurisdiction."); *Jill S. Levenson & Kristen M. Zgoba*, "Community Protection Policies and Repeat Sexual Offenses in Florida," 60 *Int'l J. Offender Therapy & Comp. Criminology* 1140, 1147 (2016) (finding, based on analysis of Florida data from 1990 to 2010, that "on average, each year, 6.5% of the sex crime arrests were [of] an individual with a previous conviction for a felony sex crime").

63 See *Michael Planty et al.* U.S. DOJ, Female Victims of Sexual Violence, 1994-2010, at 4 tbl. 3 (2013), https://www.bjs.gov/content/pub/pdf/fvsv9410.pdf [https://perma.cc/5J58-HGC3[] (showing that 78% of female sexual assault victims between 2005 and 2010 reported that their attacker was not a stranger).

64 *Robert A. Prentky et al.*, "Sexually Violent Predators in the Courtroom: Science on Trial," 12 *Psychol. Pub. Pol'y & L.* 357, 377 (2006) (estimating that risk of sexual reoffense can be expected to drop by about 2% each year after age 40).

65 *R. Karl Hanson et al.*, "Reductions in Risk Based on Time Offense-Free in the Community: Once a Sexual Offender, Not Always a Sexual Offender," 24 *Psychol. Pub. Pol'y & L.* 48, 57 (2018).

66 *Id.*

79 See *Jefferson Knighton et al.*, "How Likely Is 'Likely to Reoffend' in Sex Offender Civil Commitment Trials?," 38 *Law & Human Behav.* 293, at 294 (identifying four different approaches used by different states).

80 *Id.* at 295-96 (listing controlling legal standards in all civil commitment states).

81 *Id.* at 298-99.

82 *Id.* at 299-300.

85 *Id.* at 302. Imprecision also affects a second key requirement for civil commitment – the presence of a mental abnormality or disorder. For instance, one common diagnosis in civil commitment proceedings is "paraphilia not otherwise specified [NOS] – nonconsent." See *Prentky et al., supra* note 64, at 366. This diagnosis purports to cover individuals who are sexually aroused by the resistance of a prospective sexual partner, which might indicate a predisposition to commit rape. See *id.* (describing various paraphilias, which "are fantasies, urges, and behaviors that reflect atypical, nonconformative, or deviant expressions of sexual gratification"). However, there is little research to support the validity of this diagnosis or establish criteria for its application. *Id.* Critics characterize it as a "wastebasket" diagnosis, so amorphous that it could be applied to "all sexual offenders with multiple offenses (spanning at least 6 months)." *Id* at 367.

96 See *Andrew J. Harris*, "Policy Implications of New York's Sex Offender Civil Management Assessment Process," 16 *Criminology & Pub. Pol'y* 949, at 950 ("Although the U.S. Supreme Court has repeatedly affirmed [SVP civil commitment's] underlying constitutionality, these rulings have been based on the premise that states will furnish a therapeutic environment, offer services to address the mental conditions that formed the basis oif the initial commitment, and provide viable pathways toward eventual release."(citations omitted)).

99 *Eric S. Janus*, "Beyond Strict Scrutiny: Forbidden Purpose and the 'Civil Commitment' Power," 21 *New Crim. L. Rev.* 345, 347 (2018).

100 *Monica Davey*, "A New Look at Sex Offenders and Lockups that Never End," *N.Y. Times*, Oct. 30, 2015, at A1.

101 *Id.*

102 For all violent offenses, prevalence rates peak in the teen years and then tail off in adulthood. *Prentky et al., supra* note 64, at 375-76. With respect to sexual offending in particular, much research points to steadily declining sexual desire and activity in middle age and thereafter, *id.* at 376, which likely complements the normal tendency for individuals to desist from crime as they age.

103 *Id.* at 377 ("The most conservative adjustment would use a hazard rate of .98, indicating a reduction in recidivism risk of approximately 2% per year after age 40.").

104 *Id.* at 375 ("Legislation tends to be applied to older sex offenders because such legislation is generally applied to higher risk offenders after they have achieved a lengthy criminal record and because such legislation is most often applied after the offender has served a lengthy criminal record.").

105 See *id.* at 360 ("The high political salience of sexual predator policy combines with the real harm caused by sexual violence to elevate concern for false negative judgments over concern about false positives.")

111 *Lucy Massopust & Raina Borelli*, "'A Perfect Storm': Minnesota's Sex Offender Program – More than Twenty Years Without Successful Reintegration," 41 *Wm. Mitchell L. Rev.* 706, at 708-09 (2015) ("According to this recent survey, Minnesota commits 130.2 sex offenders per million people, whereas the next highest respondent state, Kansas, commits only 84.6 sex offenders per million people.").

112 *Karsjens v. Jesson*, 109 F. Supp. 3d 1139, 1151 (D. Minn. 2015), rev'd on other grounds sub nom. *Karsjens v. Piper*, 845 F.3d 394 (8th Cir. 2017).

113 *Id.* at 1154 ("There are no reports or assessments conducted at the time of admission to determine what phase of treatment a committed individual should be placed in at the MSOP. ...The MSOP does not have a practice of considering past participation in sex offender treatment when placing committed individuals into assigned treatment phases or when attempting to individualize treatment.").

114 *Id.* at 1156 ("A former MSOP Clinical Supervisor, credibly testified that she frequently saw individuals' scores on the Matrix factors fluctuate, due to changes in staffing, and that she was concerned by the lack of inter-rater reliability of the Matrix factors.").

115 *Id.* at 1156-57.

116 *Id.* at 1158.

117 *Prentky et al., supra* note 64, at 381.

118 Recent estimates suggest that the institutionalized civil-commitment population is about ten times larger than the community-supervised population. *Harris, supra* note 96, at 950.

119 *Martin Schmucker & Friedrich Losel*, "The Effects of Sexual Offender Treatment on Recidivism: An International Meta-Analysis of Sound Quality Evaluations," 11 *J. Exper. Criminology* 597, at 621 (2015) ("There was a tendency that outpatient treatment fared better than treatment in prisons. The difference in favor of community programs is in agreement with the general research on 'what works' in correctional treatment.' (citations omitted)).

120 *Prentky et al., supra* note 64, at 381.

121 *Neil P. Cohen et al.*, *Criminal Procedure: The Post-Investigative Process* 735-36 (5th ed. 2019) (describing halfway house as a "relatively small residential facility where offenders live when not at work or in therapeutic or educational program").

122 *Id.* at 734-35.

123 *O'Hear, supra* note 27, at 51-52 ("Rather than meeting with a [parole officer] once or twice a month, an offender on [intensive supervision] might have that many or more required meetings *per week*.").

129 See, e.g., *Harris, supra* note 96, at 952 (New York's sex offender civil management policy is also distinctive in its inclusion of both institutional and community-based (i.e., 'outpatient') dispositions for its civilly managed population."); *Massopust & Borelli, supra* note 111, at 744 (noting absence of front-end diversion options in Minnesota and Wisconsin).

132 See *supra* note 64 and accompanying text.

135 See *supra* note 80 and accompanying text.

139 See *supra* note 119 and accompanying text.

252 See supra Section I.B.3 (discussing criticism of "warehousing" approach).

253 Indeed, in the not-so-distant future, emerging technologies may create a world in which almost all individuals can be safely supervised in the community. See *Mirko Bagaric, et al.*, "Technological Incarceration and the End of the Prison Crisis," 108 *J. Crim. L. & Criminology* 73, 78-79 (2018) (proposing system of "technological incarceration" in the community that combines GPS tracking, remote, real-time monitoring through video and other sensors; and remote-controlled, Taser-type electronic immobilization devices).

262 See Section I.B.2 (discussing impact of age on risk).

263 *Karsjens v Jesson*, 109 F.Supp.3d 1139, 1151 (D. Minn. 2015) (discussing environment of hopelessness in Minnesota Sex Offender Program).

264 *Id.* at 1156-57 ("The lack of clear guidelines for treatment completion or projected time lines for phase progression impedes a committed individual's motivation to participate in treatment for purposes of reintegration into the community.").

265 See, e.g., *Massopust & Borelli, supra*, note 111, at 730- 32 (describing required periodic review in New York and Wisconsin). But see *id.* at 730 (noting absence of required review in Minnesota).

266 See, e.g., *id.* at 732-43 (describing rules and standards for petitions in Minnesota, New York, and Wisconsin).

****

MSOP Confinees Get Free Phone Calls Restored.

Through an act by the 2024 Minnesota Legislature, all confinees in the two MSOP facilities now have the right to make all phone calls free of charge. This law change, by 2024 Laws, Chapter 125, Article 6, Section 1, enshrines this right in a new section of the Minnesota Statutes (to be codified by the Revisor of Statutes in due course) effective from July 1, 2024 forward.

Repeated references in this new law to Direct Care and Treatment (DCT) convey that affected facilities are all those now within DCT. This includes MSOP, as the foregoing article about the transition to DCT explains. This new law requires affected facilities to continue to offer the services offered as of January 1, 2024. In the case of MSOP, the recent restriction of confinees to only one phone call within a two-hour period appears to transgress this provision in the new law.

In the larger picture, the new law significantly changes and broadens confinees' rights to voice communication services by declaring categorically: "A facility must provide patients and clients with voice communication services." Thus, by way of notable examples, MSOP's longstanding bar on incoming phone calls (allowing only short voice-mail messages to confinees) appears to be barred by this doctrinal declaration. So too, for that matter, is the restriction to only certain toll-free numbers that an MSOP confinees may call.

For that matter, the recorded announcement that requires the recipient of any outgoing call to be manually accepted to allow connection of the call appears to be a 'restriction too far,' especially given the modern trend on the part of commercial firms and government offices and even attorneys' offices to employ 'phone tanks' requiring a caller (such as an MSOP confinee) to press phone pad buttons to choose how to route their call. As all MSOP confinees know, the phone system in use in their facilities bars use of such phone but-

(Continued on page 10)

tons after the entry of the phone number called, save only legal calls and other staff-facilitated phone calls. This exception shows that this is not an inherent electronic limitation of the system, but instead is a policy choice by MSOP without any officially stated rationale. This sweeping bar on use of such button usage is a massive limitation of voice communication that surely seems not sustainable under this new law.

Interestingly, apparently a first for Minnesota legislation, the new statute also specifically allows, but does not require, affected facilities to provide "other communication services, including but not limited to video communication and email or electronic messaging services." The "including but not limited to" language would appear to further allow Internet connectivity and use to be established by affected facilities.

This legislation may have substantial interplay with First Amendment case law. Previous judicial challenges to categorical denial of Internet connectivity have been denied on opposing arguments, which raised a specter of harm to the public by unrestrained Internet communication by MSOP confinees. Such arguments were purely speculative given a lack of significant numbers of adverse events from former email use by MSOP confinees. No extant statute, rule, or DCT or MSOP "policy" categorically prohibits MSOP confinee access to the Internet. The new statutory allowance implies a lack of significant public harm from such communication, or at least the impermissibility of applying a presumption of such harm.

All communication services offered must be without charge both to the confinee and to any person outside the facility with whom the communication occurs. This appears to quash previous proposals made by various service providers, for instance, to provide email service to confinees (incoming and/or outgoing, but only if paid for by outside senders or by confinees sending to outsiders).

****

CURE National Civil Commitment Project Emphasizes: SOCC Must End Now!

[Editor's Note: All emphases in the quoted material below appeared in the original text.]

A recent press release by CURE National's sex offender civil commitment opposition project states, "...While being highly cognizant of the conditions incurred by the approximately 6500-7000 men being held in sex offender civil commitment ("SOCC") ['shadow prisons'] in 20 states and by the federal government, many in excess of 20 years, it is agreed that efforts need to be focused on **ending civil commitment**."

During recent monthly conference calls, participants have learned about efforts three states are taking to bring sex offender civil commitment (SOCC) to an end.

In Minnesota, the Sex Offense Litigation and Policy Resource Center (SOLPRC), an organization under the auspices of the Mitchell Hamline School of Law in St. Paul and led by its Past Dean and Professor Emeritus Eric Janus released a report in April scathing Minnesota's SOCC, the Minnesota Sex Offender Program ("MSOP") and calling for its shutdown via a "sunsetting" process over the near future.

In June, this organization and "MnCASA," the state's oldest and most respected NGO seeking an end to all sex offending, collaborated in bringing together 170 experts and activists from throughout the state for an all-day conference. They agreed that ending MSOP is necessary, with reinvestment of its massive annual cost of operation to programs in the state that seek to prevent sexual offenses proactively, rather than merely reacting after-the-fact.

Such educational programs have proved that they work, but have had their effectiveness strangled by lack of funding. Additionally, although Minnesota also has a number of community treatment programs for sex offenders, they too have starved for funding despite having shown that their comparatively short treatment regimens can bring former sex offenders to a lifetime of desistance from further crimes.

The "sunset and reinvest" plan they advocate will allow the future without sexual offending to become a reality. Discussions are currently underway toward drafting legislation that can be passed next year to put this plan into action.

In Illinois, five individuals went to the state capitol in April of this year and distributed information needed to convince state elected officials to end civil commitment, including that Minnesota detailed and scholarly report released in April advocating that end. These five Illinois individuals met with the Senate Judiciary chairperson, who responded that she was already scheduled to visit the commitment center. The five stated their intent to return to the Capitol in January 2025 for further advocacy to that end.

In Kansas, a number of family and friends of those confined in the Kansas SOCC facilities have been meeting via Zoom to discuss ideas they believe will convince state officials to begin the process of ending civil commitment. The Kansas group is fortunate to have highly knowledgeable individuals working with them by providing assistance and ideas how best to approach bringing SOCC to an end.

In earlier months this year, some advocates went to the Kansas capitol and met with legislators. For those whom this group was unable to meet with, information was distributed supporting the end to SOCC. Follow-up email messages were sent to all Kansas legislators. "Pushback" they have heard centers almost exclusively on money opponents fear will be lost through such closures. They are currently learning the Minnesota 'sunset-and-reinvest' proposal, which does not "lose" any money, but unlike committing sex offender for what happened in the past and pure conjecture of future recidivism (which happens only rarely), simply redirects state funding to ideas that actually work to end sexual offending.

Texas advocates are also visiting legislators in continued efforts to sunset SOCC. Minnesota advocates against SOCC hold regular Zoom meetings frequently to lay further plans for advocacy and action to bring about the end to SOCC. CURE National's transmittal continues:

"If you have concerns/questions/issues or comments regarding legal or forensic matters as to sex offender civil commitment ("SOCC") or challenges which may free you from it, Cyrus Gladden, whose address is at the bottom-left of the front page of each edition of *the Legal Pad* ("*tLP*") monthly newsletter, has dialoged with many in the 20 states and the federal government having SOCC laws. He does not provide legal advice, but can oftentimes steer an inquiring correspondent in a direction that may prove helpful. However Mr. Gladden asks of those who have any outside support person(s) to first have them check the archive of past editions of *tLP* appearing at http://www.cure-sort.org/the-legal-pad.html for any obvious answers to your question(s). The complete table of contents to all *tLP* editions to date that can be found there is searchable by word or phrase for that purpose. *The Legal Pad* editions are downloadable for free from this web page.

Separately, regular writers of the articles appearing in *tLP* are always interested in hearing from people regarding activities, concerns, etc. concerning SOCC and anything related to it. Inquiries/comments will be forwarded on to any specific writer upon request. We must work as a group, those detained and those not.

PLEASE SHARE this information, plus any other information you have available, with others, as well as family and friends. We need EVERYONE to become involved in whatever capacity hey can. We must work together to advocate for ending civil commitment. EDUCATE, INFORM, AND COMMUNICATE!

Commentary — Page 10 of the May 1, 2024 *tLP* edition includes the article "Ending SOCC Depends on You!" Please study it. It encourages involvement and suggestions for ending civil commitment.

Remember, your state elected officials statutorily created civil commitment regarding civil commitment, and other than a few operators (i.e., psychologists employed or contracted by the state for civil commitment centers, private for-profit entities), there is no one supporting it.

There are a few men who are working to keep state elected officials informed — of the horrendous waste (failed experiment, panicked legislation) that has forever impacted the lives of men who have already served their prison sentences. Also worth noting is the fact that the approximately 650-7000 individuals incarcerated in SOCC 'shadow prisons' are all male!

There are several civilly committed men who do communicate with state elected officials and that is comforting to know for those family/friends who are advocating for humane treatment for those civilly confined.

BUT we have not nearly enough civilly committed men actively advocating with us, in respect to sharing information, advocacy letters, etc., with state elected officials. We are a small group of advocates with real facts, etc., and calling for an end to SOCC.

***The Legal Pad*, published monthly, is a priceless resource for learning about civil commitment. It contains in-depth discussion of matters that impact civilly committed individuals, and that is a great foundation for supporting why civil commitment must end. The editors deserve much praise for their hard work and dedication in producing *the Legal Pad*. Consider, if allowed, writing to them with a huge 'thank you' for all the work they put in to produce *the Legal Pad*.**

We can provide sample letters (example: the Mitchell Hamline School of Law correspondence to the Minnesota governor and state legislators). Brochures can be prepared for your state, etc.

Again, the 'evidence' is there to shut down civil commitment! Here are just some of its sources, both by verbal accounts and documents: law professors, psychologists, APA, judges, attorneys, state elected officials, and former staff members at civil commitment facilities. We have it, and can access far more of it via them. Once this evidence is amassed and organized, none of the wrongdoers who currently perpetuate this evil system will have anywhere left in which they can hide their misdeeds. So the only question you must answer is, what are you waiting for!?!

As always, encourage family, friends, and loved ones to work with us to END SOCC **ENDING CIVIL COMMITMENT OF SEX OFFENDERS CAN HAPPEN, WITH EVERYONE'S INVOLVEMENT — WHEN ONE STATE'S SOCC IS SHUT-DOWN, THE REST WILL FOLLOW.**

If you know anyone who would like to join the monthly calls, please have them send an email to:

eldoncdillingham@gmail.com

(NOTE this corrected email address).

With the exception of legal holidays, monthly CURE Civil Commitment conference calls are held the first Saturday of each month, beginning at 9:00 AM **Central Standard Time**. The calls are informal and a great opportunity for friends, family, advocates for change (**end civil commitment**), and just to meet one another."

****

the Legal Pad

Editor: Cyrus P. Gladden II

Editorial Advisory Board:

Peter Lonergan *Ray Semler*

Rodger Robb *Michael Benson*