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the Legal Pad: Giving you the truth when everyone else refuses to.

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What Does Freedom Mean to You?

What Does Freedom Mean To You?
by *Cyrus Patrick Gladden II*

"This is not a test."

On this 248th anniversary of the signing of the Declaration of Independence by our nation's forefathers, the question arises: What does independence mean to you, from this perspective of indefinite pseudo-incarceration claimed to be for preventive detention, but really just as further punishment for crimes in the distant past?

A little lesson from history may inspire us. The Declaration of Independence didn't just spring out from the heads of some visionaries. It was first preceded by a period of worsening relationships with Great Britain, and ultimately during the last year and a quarter beforehand, by military skirmishes and even actual battles (for instance, Bunker Hill) with English troops brought in to suppress unrest by colonists.

The force exerted by large armed forces from England emphatically underscored that the Crown was making only empty gestures toward conciliation, while striking down every hint of dissent — often by seizing those rumored to utter it and incarcerating them in chains on prison ships anchored offshore.

Thus, by April 1776 most colonists had become convinced that separation was necessary and inevitable, only asking when and how. At a time when there was no central government, or even a country, representatives — already convened in a hitherto loosely organized "Continental Congress" — wrangled with those questions over more than two months.

The Declaration of Independence was written largely by Thomas Jefferson, who had already displayed talent as a writer of political philosophy. At the request of his fellow committee members he wrote the first official draft. Committee members made a number of merely semantic changes, and they also expanded somewhat the list of charges against the king.

The Congress deleted a condemnation of the British people, and, dismayingly to Jefferson, also deleted a denunciation of the African slave trade, at the insistence of some Southern delegates.

Ironically, the concepts espoused by the Declaration were nothing new at the time, and indeed, arose from English philosophers and political theorists themselves, especially as the Age of

Abandoning any claim based on the rights of Englishmen, however, the Declaration put forth the more fundamental doctrines of natural rights of ***all*** men and of government under social contract, ideas that were truly novel at the time. Thus, the Declaration was an attempt to assert a new doctrine for the ages, one morally just and politically valid. The right of the colonists to government ultimately of their own choice was valid — and so too is that same right to this very day.

Some of the phrases of the Declaration have steadily exerted profound influence in the United States, especially the proclamation that, "We

hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."

This quote usually omits the immediately following phrase that finishes the point: -- "That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed, -- That whenever any Form of Government becomes destructive of these ends, it is the Right of the People to alter or to abolish it..."

The Declaration cited notions of "despotism" and "tyranny" that previously were not much considered, and specifically decried incarceration other than for conviction of crime, and expressly denounced "mock trials," which we know all too well. Other phrases and assertions boldly advance ideas that are additionally sprinkled throughout, sowing seeds of inspiration for all humanity, such as: "...to assume among the powers of the earth, the separate and equal station to which the Laws of Nature and of Nature's God entitle them"

Not to be ignored or read lightly: Knowing full well that if the Revolution thus commenced should fail the heads of each signer would be displayed on pikes in encampments of victorious enemy soldiers, the signers close the Declaration with these solemn words: "And for the support of this Declaration, with a firm reliance on the protection of Divine Providence, we mutually pledge to each other our Lives, our Fortunes and our sacred Honor."

Signing followed, with John Hancock famously signing first and in a center location on the page in large and clear lettering, explaining that if the British came for him, he wanted no mistake or uncertainty of his identity to intervene. We can

Almost immediately after the American Revolution was over, the Declaration inspired others elsewhere to overthrow their own masters, for instance in France, and later in the Hispanic colonies of the Americas.

Today, however, much of that noble luster on the concepts advanced so heroically back then seems tarnished by all of the vilifying trash-talk that causes people in these United States to study their neighbors with distrust of suspected motivations. I sometimes close my eyes and visualize the stars on the flag so many of our ancestors have died to preserve falling from their place in embarrassment and sadness to symbolize these United States under such conditions of disunity and distrust.

The very fact that we now languish in this Prison of Others' Fear and Loathing bespeaks the willingness of the masses to forget about constitutional guarantees that arose from those pre-Revolutionary abuses by that dictatorial government. This includes Bills of Attainder (which then served the very same purpose of locking up those thought likely to cause trouble or to violate laws) and abrupt and arbitrary actions, including legislative acts and judicial orders unjustified by the actual facts (giving rise to the constitutional guarantee of substantive due process).

If we are to keep our nation, we must all rise above this fear and hatred of each other and accord to each other brotherliness and presumptive trust in one's sanity and moral conscience. We cannot be constantly driven by fears of imagined scary monsters in human form, whether suspected to be under the bed or just around the corner.

Like Abraham Lincoln later stated on that starkly gray and chill November day when standing on the Gettysburg battlefield in the Civil War that inevitably followed from that failure to initially condemn and abolish slavery, the nation is always subject to testing whether, conceived in liberty and equality of rights, it can "long endure."

We do not deceive ourselves that our own plight will be more than "little noted" or will be "long remembered," as Uncle Abraham lamented about his words. Nor do we claim any pride in the criminal deeds of our younger years, only in the distance and maturity that lies between then and now, as we yearn only for peaceable, law-abiding years with which to conclude our lives.

More broadly, in this moment, we as a people have so preoccupied ourselves with such fears and hatred of conjured vile images of each other that we have forgotten to take precaution against the menacing malice of those despots in other lands and their robotic followers who so clearly mean our country harm, if not outright annihilation.

Thus, this is another such test of national endurance — which it is reasonable to believe that we will face as a people urgently and lethally all too soon, requiring heroic acts of that "last full measure of devotion." Our enemies seek to continue and heighten our internal distraction and obses- our defenses against those mortal enemies.

This, then, is the test. Let us all not fail it, so that, when you hear in deadly earnest the Civil Defense announcement that is no test, our government, of the people, by the people, and for the people, shall not perish from the Earth.

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Editor's Note: On Friday, August 16, 2024, Daniel A. Wilson, tireless advocate of truth and for our collective rights, was surprisingly accosted for unknown reasons and immediately placed in segregation, where he remains at this writing. Send him expressions of support and solidarity.

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Florida: Another Report from the Privatized. Are You Receiving Clearly Yet?

Gary L. Perrot, Excerpts from personal letter dated July 26, 2024

Text Excerpts: "…The Florida Civil Commitment Center [FCCC] has always been operated by a private contractor. In order, the companies were: Liberty Behavioral Health; GEO, which spun off GEO Care specifically for Florida mental health facilities, which was bought out by Correct Care which eventually merged with another company to form Wellpath Solutions, which had Wellpath Recovery Solutions, which was the Florida division. Wellpath Solutions turned into Wellpath Care nationally and Recovery Solutions in Florida. Wellpath Care and Recovery Solutions is owned by H.I.G. Capital, a private equity investment firm. Unfortunately, because everything is private you cannot obtain any real financial data. Since Liberty it has been the same people in the FCCC administration. Promotions for the most part came from within the company as they are only looking for "Yes Men." (and women).

When it comes to privatization there is one word that runs like a thread throughout all private companies. CHEAP! They all could care less about the quality of life for their 'residents.' It's all about making money with them. For instance:

When it comes to medical everything must be 'medically necessary.' There is nothing done preventative.

…[W]hen you finally see an outside specialist the facility either does not pay them or pays so late that the doctors no longer want to do business with the FCCC. We can no longer see local doctors for this medical. [illegible]

Sometimes it can take a week or more just to be seen for sick call here at the facility. By the time you get seen you're either RSV vaccines. They cost too much. The medical care was much better when GEO had the facility. Unfortunately, the facility doctor has his hands tied by corporate.

Medical is always short staffed. We have gone through three facility ARNP's and three M.D.s in as many years. There was an almost six-month period where we had no ARNP and no M.D. on staff.

Another example: Food Service – Out of the resident food service budget the facility orders spare ribs, pork chops, pork roast, shrimp, and other excellent food for the staff, whereas the residents get the food consisting of the poorest quality possible: french fries, ground turkey, chicken, chicken, and more chicken, Hamburger Helper-type meals with ground turkey and chicken, chicken, and more chicken. Quite frankly, they are chickening us to death. We do get 'hamburger' patties but have no idea what is in them, it is definitely not ground beef.

The FCCC is understaffed, mainly because they treat their rank and file employees just as bad as they treat the residents. Staff are routinely forced to work overtime.

When they take you off the compound for any reason you are in handcuffs, black-box, belly chain, leg irons. In sum, you're trussed up like a Christmas turkey. It is very uncomfortable and it is almost impossible to urinate in one of those plastic urine containers they use for trips.

They constantly cover things up. When a staff member gets caught bringing in drugs or other contraband they are merely 'forced to resign.' No police involvement and no incident reports are ever written….

On Friday, July 19th a resident was discovered in a clinician's office. We have heard, but it has not yet been confirmed, that the resident was discovered under the clinician's desk. The clinician was seated in her chair with her pants down/off while the resident was performing oral sex on her. The clinician was escorted off the compound. She then claimed she was raped. The resident was thrown into confinement and when he found out she yelled that she was raped, the resident hung himself in his confinement cell. That could not be covered up but as of July 25th we have yet to see media involvement or reporting on it. We do know that this incident is being investigated by the FDLE and DeSoto County SO….

The facility/Recovery Solutions/DCF has no say-so in who gets out and when. All that is set forth by statute… However, Recovery Solutions does complete an annual Treatment Progress Report which always states that the resident can benefit from more treatment. The Treatment Progress Report never contains a risk assessment so it is of little value for a court annual review. Those court annual reviews involve evaluations by independent, outside, psy- the liability issue should they recommend someone for release and they then reoffend.

…[T]here is no difference in rates of recidi- [illegible] don't….

The facility used to be an open compound. The facility is now controlled movement every hour. No more hanging out in the breezeway and hallways or going to the canteen whenever you want to. The FCC is now truly a prison….

They pay $1.00 per hour for work here with most 'jobs' being 12 to 15 hours per week. More hours are usually available for kitchen workers. You do not make enough to pay taxes. There has never been a pay increase here. They cannot force you to work. When you do work they treat you [disrespectfully] and work you like a dog. I told them to stick their jobs … long ago. Work includes food service, tutors, housemen, shower cleaners, wall washers, painters, maintenance, various 'aides,' medical 'sitters' and janitors, etc. Nothing of any real value. It's all menial labor crap.

There is no legal assistance here. If you get caught with someone else's legal work you are going to confinement. No exceptions. We can do legal research on the tablets and on six computers in the computer lab. There are 20 computers in the computer lab, six for legal work, the rest for treatment and personal use. You cannot install any programs on them, they stopped that years ago and the computers are now so 'locked down' that all you can do is word processing on them with limited other use.

When they started using the Smartmail system they stopped opening mail sent here in our presence. They still open all mail received here, but now if you receive personal mail here at the FCCC they just open it and throw it away. I have had a money order stolen and others have had stamps stolen. The facility never investigates and always denies any wrongdoing. They started using the Smartmail system to eliminate the introduction of drugs via soaking the mail in various substances. But since they started using Smartmail the amount of drugs entering the facility has only increased …a lot.

…Residents used to be able to purchase craft items, yarn, paints, guitars, and other things but most of that has stopped. The residents just lay down and refuse to fight. Since 2014 there has only been five grievances that have been overturned at the corporate level. DCF [a state agency] takes to part in the grievance process.

They have GED programs. No college programs, No trade or licensing programs. They have computer literacy but that consists of only what they want to teach you and even that is very limited; nothing in depth. No certificate programs. In sum, education here is a joke."

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Can Categorical Denial of a Sex Crime Aid Recidivism Risk?

Jayson Ware et al., "Are Categorical Deniers Different? Understanding Demographic, with Sexual Convictions," *41(4) Deviant Behav.* 399-412 (April 2020)

Text Excerpts:

p. 399: "Large scale meta-analyses have found no overall effect for denial as a predictor of sexual recidivism (Hanson & Morton-Bourgon 2005; Mann, Karl Hanson, & Thornton 2010). Despite this finding, 91% of treatment programs in the US included 'offender responsibility' as a treatment target.

p. 400: …Recently there has been evidence to suggest that denial may actually work as a protective factor for some sexual offenders. (Marshall, Marshall, & Kingston 2011) reported denial to be negatively related to items on three risk instruments (STATIC-99, VRS-SO, STABLE 2000), suggesting that denial may actually signal a lower chance of reoffending. Harkins, Beech, & Goodwill (2010) found that high risk high denial offenders were less likely to recidivate than low risk low denial sexual offenders. Harkin et al (2015) examined the relationship between denial, risk, and sexual recidivism among different types of sexual offenders. Denial of responsibility predicted lower levels of sexual recidivism, independent of risk level. For specific offender types, denial of responsibility was not significantly associated with sexual or violent recidivism. While denial may not have an effect on recidivism, it has been argued that denial still represents an important responsivity factor and one which is important to understand (Levenson, David Prescott, and Jumper 2014).

p. 403: On average, deniers were significantly older (M = 52.73 years; SD = 10.74 than admitters (M = 46.03 years, SDS = 13.22, t(75) = 2.45, p = .017, d = 0.56. There was an over-representation of offenders with child victims among deniers, while this was not the case among those who admitted their offenses….

p. 405: There was a significant multivariate effect, indicating some degree of difference between the two groups [admitter and deniers] across these measures. Examining each of the between-groups contrasts, significant differences were present in relation to …shame proneness (with deniers scoring higher than admitters), and externalizing self-consciousness (with deniers scoring higher than admitters).

p. 406: Discussion

…Sex offenders were categorized as being in categorical denial only if they denied responsibility for *all* current and historical sexual convictions,…. Denials scored significantly lower on anti-social and sadistic, which may help to explain why some deniers recidivate at lower levels (Harkins et al. 2015). Interestingly, categorical deniers did not score significantly higher on self-deception scales (Lanyon & Lutz 1984)

p. 407: …[T]he enacting of the 'moral' or 'desirable' selves often espoused by deni- and self-appraisals (Harter, Waters, and Whitesell 1998).

Implications for practice

Traditionally the first role for the clinician [illegible] through' the denial of their offenses (Northey 1999). However, given the function of denial, its role in identity management and shame reduction, and in maintaining family and peer networks, such a clinical role is untenable and likely to be met with resistance (Roberts & Baim 1999). The results of this study support the approach to treatment by Marshall and colleagues (Marshall et al. 2001; Ware & Marshal 2008) in which there is no immediate or default attempt to overcome denial. Instead, treatment commences with the strategy of helping the offender identify problems in his life that led him to be in a position where he could be accused of sexual offending. This engages the offender in treatment in the first instance and provides the therapist with the opportunity to develop

a stronger therapeutic alliance built around mutual trust. It also allows the therapist the opportunity to understand the function of the denial for the offender and to develop strategies to address the actual issues that maintain the denial (such as the striving to maintain family support and/or a viable personal identity) without the therapist having to actually seek to challenge the denial. In doing so, this prevents the therapist from being perceived as confrontational or inflexible to the needs of the individual that they were engaged with. Given the shame linked with denial it is important that therapeutic relationship avoid confrontation and practices which may increase shame. The shift towards non-disclosure and non-confrontational practice with individuals with sexual convictions are consistent with contemporary, trauma-informed methods of SO treatment (Levenson, Willis, and Prescott 2016) and compassion-focused practices (Walton & Hocken 2018).

pp. 407-08: It has been argued that the quality of the therapeutic relationship is of primary importance in working with the experiences of both shame and guilt in any clinical setting (Clark 2012). Blagden et al. 2013) found that therapists who worked with sexual offenders recognized the importance of negative affective states, particularly shame, when treating such offenders. They argued that a therapist's reactions to shame may, in part, determine the level of defense mechanisms utilized by sexual offenders. For instance, a therapist who recognizes that the offender's offending behavior is the result of the person looking to pursue the human need/desire for specific experiences (albeit in maladaptive ways), rather than the offender being of 'bad' character, is likely to decrease shame responses in the form of denial (Ward, Vess, Collie, and Gannon 2006). Thus, a collaborative therapeutic alliance built on authentic approach goals is likely to breakdown resistance and facilitate a positive and predictive relationship. Indeed, given that many individuals with sexual convictions will have a history of abuse and trauma, the therapeutic relationship could be the most meaningful encounter they have ever had. (Levenson, Willis, & Prescott. 2016)."

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Nationally: Sex Offender Shocking Harms from Registry Use.

Hristina Nikolovska, "Sex Offender Statistics [2023 Update]," *Screen & Reveal*, May 11, 2023, https://screenandreveal.com/sex-offenders-stats/.

Text: "Sex Offender Facts and Statistics (The Highlights)

- There are over 786,000 people on the U.S. sex offenders registry.
- 44.5% of those on the sex offender registry are required to register for more than 25 years.
- 56.3% of adult registered sex offenders have lost their jobs due to being on the registry.
- At 29.6%, distributing, manufacturing, or possessing child pornography materials is the most common reason for conviction among registered sex offenders.
- Statutory rape convictions account for the next-most-common reason, at 22%.
- The least common type of conviction among those on the registry is sex trafficking, kidnapping, etc. at 0.1% (one out of a thousand).
- In 36.1% of cases, the victims of adult registered sex offenders are family members.
- Only 7.1% of victims of those registered for a sex crime were 18 or older at the time of the crime. Rather than reflect a true overwhelming percentage of minor victims, this likely is explained by the fact that 37.6% of those registered had been convicted of a reduced (but still registrable) offense. The additional number who instead pled guilty to a non-registrable offense is not shown by the registry. But the small number of registrable rape offenses perpetrated against adults is very likely due to relatively lax plea negotiation practices by prosecutors in the case of adult victims and highly likely refusal to negotiate at all by prosecutors in the case of minor victims.
- 44.5% of offenders on the sex offender registry are required to register for more than 25 years; only 4.5% of sex offenders will need to register less than 10 years.
- 37.2% of sex offenders are not told how long they will stay on the registry.
- Since the time their registration started, later legislation has increased the minimum time of registration for 27% of registrants.
- The largest category of registrants (31.4%) have not been assigned a risk tier level at all. An additional 17.4% don't know whether they have a risk tier level assigned or what it might be.
- Only 5.5% of registrants have ever managed to get their risk tier level reduced, despite the nominal availability of a procedure to apply for such a reduction.
- 89.8% of sex offenders have been victims of violence and harassment due to being on the registry.
  - *Lost a friend: 75.4%
  - *Denied contact with children or family members: 62.4%
  - *Unable to date, have sex/intimate partners 48.2%
- Employment problems due to registration:
  - *56.3% of registered adult sex offenders have lost a job due to being in the registry.
  - *Another 30.8% have been denied a promotion for the same reason.
  - *21.78% are involuntarily unemployed; 15.7% have been unemployed 1 year or more.
  - *8.5% were forced to take part-time employment.
- Housing problems due to being registered:
  - *Difficulty finding a place to live not close to school, bus stop, park, or playground or other forbidden area: 64.8%
  - *Landlord refusing to rent due to registry 50%
  - *Inability to live with supportive family members due to residence restrictions: 47.4%

Reasons for moving:

- *Financial reasons due to registry: 29.4%
- *Legal restrictions: 28.4%
- *Difficulties related to registry (e.g., harassment): 22.1%

International travel restrictions:

While registered sex offenders are allowed to have passports, they are currently not allowed to travel to Australia, Canada, China, Japan, Russia, Thailand, and the UK.

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Whatever Happened to Promises of Treatment and Prompt Release?

(contributed by Matthew Feeney), "DR 2511 Request for Summary Data," (April 2024).

Text/Table Excerpts: [with editorial comments attached:]

"1. How many total petitions have clients submitted for SRB?"

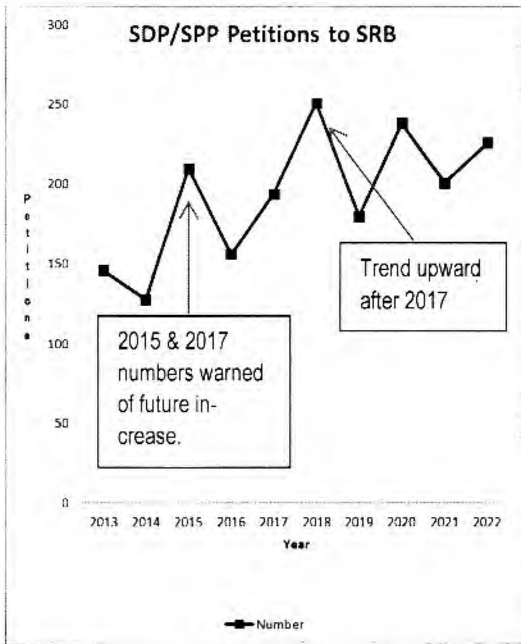
Year	SDP/ SPP # Petitions
2013	146
2014	128
2015	210
2016	156
2017	194
2018	251
2019	180
2020	238
2021	201

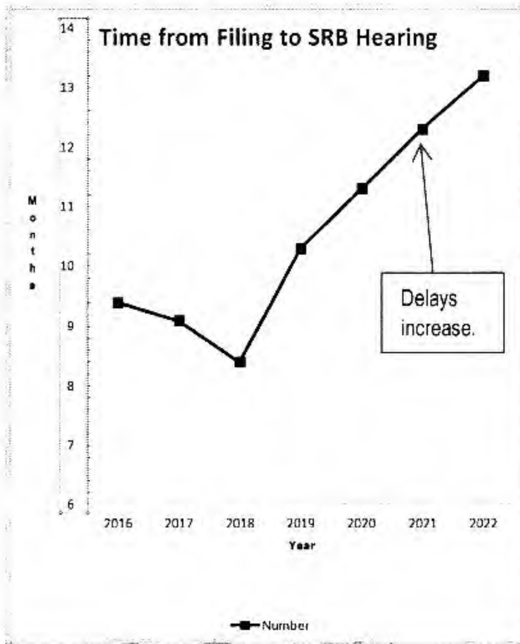
Total SRB petitions for 2013-2022: 1,930

2. "Length of time in months ...from clients filing their applications to their actual SRB hearing?"

[See next page.]

(Continued on page 4)





Year	Average Length (months)
2016	9.4
2017	9.1
2018	8.4
2019	10.3
2020	11.3
2021	12.3
2022	13.2

4. "Length of time in months from clients filing appeals to their actual CAP hearing?

Client-Filed Petitions

(# = 628)

	Months
Average:	11.67
Longest:	38.1

5-7. **Length of time in months (shortest, longest, and average) from first admission to:**

CPS Status; Provisional Discharge Status; Full Discharge Status:

Response:

Length of time in months from first admission

(Data from 2009 to present):

OVER 30 YEARS!

	CPS	Provisional Discharge	Full Discharge
Shortest	19	88	91
Longest	364	351	356
Average	162.7	209.5	211.5

ALMOST 14 YEARS! **17.5 YEARS!** **ALMOST 18 YEARS!**

Data as of 3/22/24:

14. For current clients in the secured perimeter, how many (number and percent) are "Juvenile Only Offenders"?

Current Secure Perimeter Count:

ML:	431
SP:	177
Total:	608

Clients regarded as "Juvenile-Only Offenders": 37

% "Juvenile Only Offenders" residing in the secure perimeter: 6.1%

[Implicit, unrelated revelation:

Total count both facilities (9/19/23, likely not more than a few off from 3/22/23): 746

Minus 608 secure perimeter

Equals only 138 in CPS or in some revoked -release status.

Minus the admitted # of CPS residents overall (127) yields 11 unaccounted for. These 11 are probably recently revoked.]

15. For current CPS clients, how many (number and percent) are "Juvenile Offenders"?

Current CPS Count: 127. # Clients regarded as "Juvenile-Only Offenders" at CPS: 7

% "Juvenile Only Offenders" residing in CPS: 5.5%

16. For current Provisional Discharge, how many (number and percent) are "Juvenile Only Offenders"?

Current Provisional Discharge Count [NOT "100" as claimed by MSOP elsewhere]:

PD: 61

Clients regarded as "Juvenile-Only Offenders" on PD: 2

% "Juvenile Only Offenders" residing on PD: 3.3%

17. For current Full Discharge status, how many [number and percent) are "Juvenile Only Offenders"?

Full Discharge Count – Program History 24

Clients regarded as "Juvenile-Only Offenders" discharged: 1

% "Juvenile Only Offenders" fully discharged: 4.2%"

22. SOCCPN 2023 CR Responses

"23. What percentage of all clients ever released to CR have been returned to the secure treatment facility or jail/prison for technical violations? 17.4%

24. What percentage of all clients ever released to CR have been returned to the

(Continued on page 5)

Note: This inset refers to Question 17 (p. 5): CAP Decision Data

CAP Final Order Dates 2016-2020, N=738

Outcome	CAP Decision	SRB Recommendation	Treatment Report
Grant/Support	163 (22.1%)	164 (22.2%)	96 (13.2%)
Deny/No Support	575 (77.9%)	574 (77.8%)	632 (**86.8%**)
Total	738 (100%)	738 (100%)	728* (100%)

*: 10 discharge petitions do not have SRB Treatment reports

CAP Final Order Dates 2019-2022, N=584

Outcome	CAP Decision	SRB Recommendation	Treatment Report
Grant/Support	136 (23.3%)	127 (21.8%)	105 (18.6%)
Deny/No Support	448 (76.7%)	457 (78.3%)	460 (**81.4%**)
Total	584 (100%)	584 (100%)	565** (100%)

**: 19 clients were on PD and do not have SRB treatment reports.

Note: "Treatment Report" indicates whether MSOP clinical leadership supported or did not support the reduction in custody as stated in the Special Review Board Treatment Report.

22. How many clients have been granted CPS/Provisional/Full Discharge Status?

CAP Orders granted as of 1/16/2024:

Transfer to CPS: 248

Provisional Discharge: 104*

Full Discharge: 24

*: 21 of these were included later in Full Discharge total (per Feeney 2024 Data Request #944), also stating of other 3 clients, 2 were discharged from ML & 1 discharged from CPS. However, Feeney Data Request #944 states that 102 were provisionally discharged, that 82 of these were from CPS, 17 others from SP (secure perimeter, assumedly), 2 from Moose Lake, & 1 recvd PD before "current MSOP facility housing structure." This cannot be reconciled with the "102" figure previously given. Is this a cover-up for 2 revocations?

secure treatment facility or jail/prison as a result of non-sexual offenses? 1.2%

25. What percentage of all clients ever released to CR have been returned to the secure treatment facility or jail/prison as a result of sexual offense charge? 0%

Feeney's Data Request #862:
Current clients (as of 5/9/24) who have filed a petition for a reduction in custody between 1/1/2013 and 12/31/2023. SRB petition does not include any petitions from 2024.

# Petitions	Client Count
0	100
1	156
2	142
3	160
4	126
5	40
6	8
9	1

Note: of the 100 clients with no petitions, 49 were admitted on judicial hold or civilly committed at some point during 2020-2024.

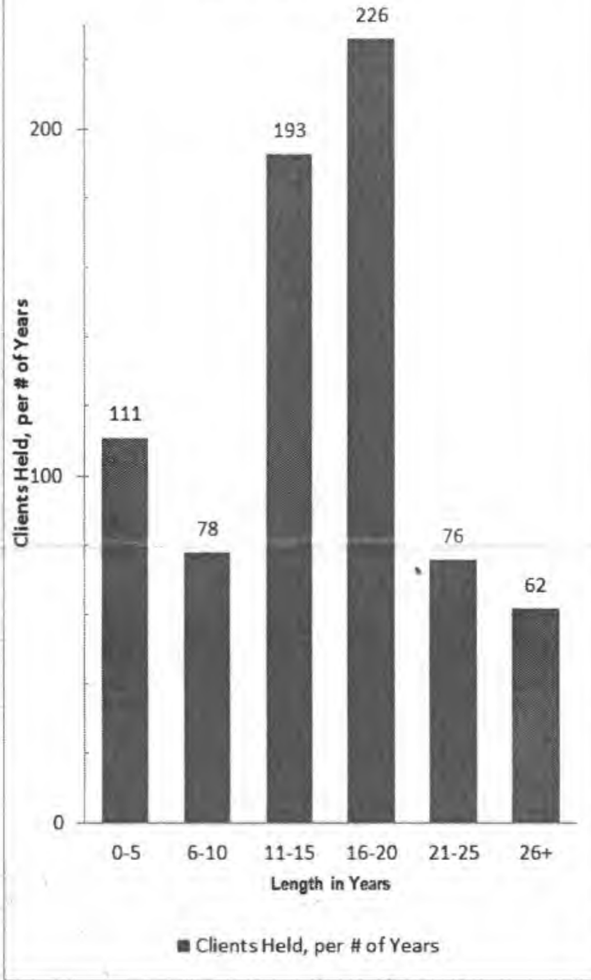
Matthew Feeney Data Request #1879
Length of time clients have been at MSOP (from first admission to 9/19/23)?

Client Count	Length in Years
111	0-5
78	6-10
193	11-15
226	16-20
76	21-25
62	26+
746	Total as of 9/19/23

CLUSTER

(At least since 2002)

(At least since 1997)



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Will the Truth Set You Free? There's Only One Way to Find Out!

Duncan Brainard, "Can You Help? Research Project on the Usefulness of MSOP Treatment," (Direct submission, May 31, 2024).

Text: "Duncan Brainard, "Can You Help? Research Project on the Usefulness of MSOP Treatment," (Direct submission, May 31, 2024, updated 8/8/24).

Text: "I am looking for 50 peers willing to share their risk assessments. I will not be collecting identifying information (name, victims or personal history). Instead I wish to compare the original assessment's risk scores to one within the last year. I am trying to determine how much benefit clients receive from their treatment programming.

If you are willing to assist me in determining whether MSOP treatment is effective for individuals, please see if you meet the following criteria:

Are you willing to share the risk assessment scores and Dynamic Risk Factors from your initial commitment?

Have you been a treatment participant for at least 4 years?

Have you had a risk assessment report in the last 2 years?

Collected data will be put into graphs depicting the least benefit, the most benefit, and average impact of treatment participation on risk scores. It will not include any data identifying participants. However, agencies receiving the research may contact me for more information. I will give you the contact information for the agency requesting further information. I will not keep any information clients share. Agencies receiving this information may include:

- The media
- Lawmakers
- The Governor's Office
- The Department of Justice
- The U.S. Senate and House of Representatives

Please contact Duncan Brainard if you are interested."

Editor's Comment: I encourage all MSOP confinees to participate in this research project. With a large participation percentage, profound truths about MSOP treatment can be derived and exposed.

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Mn DOC Findings:

With CoSA, Who Needs Long-Term Lockup of SOs?

Grant Duwe, "Can Circles of Support and Accountability (CoSA) Significantly Reduce Sexual Recidivism? Results from a Randomized Controlled Trial in Minnesota," 14 (4) Jour. of Exper. Criminology 463-484 (Dec. 2018).

Abstract Excerpts: "*Objectives*: This study evaluates the effectiveness of Minnesota Circles of Support and Accountability (MnCOSA), a sex offender reentry program implemented by the Minnesota Department of Corrections in 2008.

Methods: Using a randomized controlled trial, this study compares recidivism and cost-benefit outcomes among sex offenders in the MnCOSA (N=50) and control groups (N=50).

Results: The results suggest MnCOSA significantly reduced sexual recidivism, lowering the risk of rearrest for a new sex offense by 88%. In addition, MnCOSA significantly decreased all four measures of general recidivism, with reductions ranging in size from 49 to 57%....

Conclusions: Although difficult to implement, the CoSA model is a cost-effective intervention for sex offenders...."

Text Excerpts: "**Introduction**

[pp. 464-65:] Circles of Support and Accountability (CoSA) is a correctional program that, as its name implies, provides offenders with pro-social support. ...CoSA ...is an intervention rooted in the restorative justice (RJ) philosophy. In contrast to the retributive justice model, which considers crime as an offense against the state, the RJ approach views crime as a harm committed against both the victim and the community. Consistent with this perspective, the RJ philosophy insists that offenders accept responsibility for their actions. Like other ERJ interventions, CoSA emphasizes offender accountability and community participation. But unlike most RJ interventions, which promote restoration by involving all three parties (offenders, victims, and community members), the victims of the offenders participating in CoSA are not participants in the Circle process.

CoSA traces its modern origins to a small Mennonite community in Ontario, Canada, where a Mennonite pastor and several members of his congregation formed a Circle in 1994 to help a high-risk se offender transition from prison to the community amid a great deal of attention and concern. Due to the success of this Circle, the Mennonite Central Committee of Ontario later formed a partnership with the Correctional Service of Canada (CSC) to implement CoSA more broadly within Canada. Since 1994, more than 350 Canadian sex offenders have participated in Cireles (R.J. Wilson, Personal e-mail communication, Aug. 11, 2017).

Based on the idea that 'no one is disposable,' CoSA offers sex offenders sources of prosocial support in order to facilitate a successful return to the community. Yet, there is also an emphasis placed on the accountability of the sex offenders who participate in the Circles, which is reflected in the goal of 'no more victims' (Hannem & Petrunik 2007). Each Circle contains one primary volunteer and three to five additional community volunteers who meet with the offender (i.e., Core Member) on a weekly basis. The primary volunteer meets with the Core Member (CM) more frequently during the first 2 to 3 months following release. In addition to this 'inner Circle,' there is an 'outer Circle' consisting of community-based professionals (psychologists, law enforcement officers, supervision agents, social service workers, etc.) who volunteer their time to provide support to the inner Circle. While the length of each Circle varies, they generally last between 6 and 12 months.

As discussed in the following sections, existing research suggests CoSA is an effective correctional intervention. Findings indicate CoSA significantly reduces general recidivism (Duwe 2013); Wilson et al. 2009) and yields cost avoidance benefits (Duwe 2013). The evidence for whether it reduces sexual recidivism has not been as clear-

(Continued on page 6)

cut. Studies using quasi-experimental designs have reported reductions in sexual recidivism for Circles in Canada (Wilson et al. 2009; Wilson et al. 2005) and the UK found the Minnesota CoSA (MnCOSA) did not significantly lower sexual reoffending. To be fair, however, there was very little sexual recidivism (only one had been rearrested for a new sex offense) among the 62 sex offenders included in the MnCOSA evaluation.

This study updates the preliminary evaluation by Duwe (2013) by comparing recidivism outcomes among 100 moderate-risk sex offenders who were randomly assigned to either the MnCOSA group or the control group during the 2008-2016 period. In addition to including the 62 offenders in the original MnCOSA evaluation, this study contains 38 additional offenders (19 apiece in the MnCOSA and control groups). Moreover, it tracks recidivism outcomes for the 62 offenders in the original evaluation over a longer period of time. Therefore, in using a RCT on a larger sample over a longer follow-up period, this study presents more definitive evidence on whether CoSA has a significant effect on sexual recidivism. ...It a cost-benefit analysis.

[pp. 465-66:] **Previous research on CoSA**

...To date. There have been only four outcome evaluations of Circles in Canada (Wilson et al. 2009; Wilson et al. 2005), the UK (Bates et al. 2014) and, as discussed later in more detail, Minnesota (Duwe 2013).

...Wilson et al (2005) found that CoSA significantly reduced all three measures of recidivism – sexual, violent, and general. In a follow-up evaluation ...Wilson et al. (2009) reported that participation in CoSA significantly decreased sexual, violent, and general recidivism.

In the most recent outcome evaluation, Bates et al. (2014) examined Circles in the ers referred, but not selected, for Circles...: None of the CMs ...reoffended with a violent contact offense versus 10 (3 of which were for sex offenses) for the comparison group, a difference that Bates et al. (2014) reported was statistically significant.

The findings from these outcome evaluations suggest that CoSA is successful in decreasing recidivism, which Wilson et al. (2009) explain by pointing out that the program is consistent with the principles of effective interventions. CoSA not only diminishes the effects of rejection, loneliness, and social rejection by providing the CM with prosocial sources of support, but it also fosters balanced lifestyles, addresses criminal thinking, and stresses compliance with correctional supervision by focusing on accountability. Moreover, by helping CMs obtain human goods that cultivate personal efficacy, well-being, and a reduced risk of recidivism, Wilson et al. (2009) further claim that CoSA is consistent with the Good Lives Model (Ward 2002).

Minnesota Circles of Support and Accountability (MnCOSA)

[p. 466:] ...[I]n a study that evaluated the effects of broad community notification on highest sexual recidivism rates (Duwe and Donnay 2008).

[p. 467:] ...As noted above, the findings also showed the highest sexual recidivism rates for :Level 2 offenders, nearly doubling the rates of Level 3 offenders....

In the initial evaluation of MnCOSA, Duwe (2013) identified a number of similarities and differences between the design and operation of MnCOSA and the CoSA model that originated in Canada. The Canadian CoSA and MnCOSA programs are similar in that each one (1) contains a CM (the sex offender) and at least four to six volunteers from the community; (2) uses a covenant, which outlines the responsibilities for CMs and Circle volunteers; (3) provides volunteers with training after a selection and screening process; (4) has Circles that last up to 12 months after a CM has been released from prison; and (5) uses Outer Circles to help support Inner Circles in their work.

..But the Minnesota and Canadian CoSAs ty (a small Mennonite community), whereas MnCOSA originated with the MnDOC (a government agency); (2) MnCOSA was developed systematically in comparison with CoSA, which grew organically; (3) CoSA relied mostly on faith communities for volunteers while MnCOSA has relied heavily on local college students; (4) CoSA focused on working with prisoners released after their sentences ended while MnCOSA has typically been applied to those released from prison to correctional supervision; (5) the Circle process usually begins earlier (4 weeks prior to release) in Minnesota than in Canada; and (6) Circles meet in individuals' homes in the Canadian CoSA model but only in secure public venues in MnCOSA Bohmert et al. (2016) conducted a qualitative evaluation of MnCOSA based on in-depth interviews with CMs and Circle Volunteers. In their interviews with 10 CMs and 33 Circle Volunteers, Northcutt Bohmert et al. (2016) examined expressive (i.e., e.g., providing advice, friendship, special outing, or helping with drug abuse) and instrumental (i.e., finding housing, searching for jobs, providing money, material goods, or transportation) social support. While most of the CMs reported receiving some instrumental support, all indicated receiving expressive support. The most common type of expressive support was receiving moral or emotional support, followed by friendship and advice. Meanwhile, employment assistance was the most common form of instrumental support. Overall, CMs expressed great satisfaction with the social support they were provided, but they also reported gains especially in the areas of moral and emotional support, friendship, help with employment, and advice (Northcutt Bohmert et al. 2016).

[p. 474:] **Results**

CMs had lower rates of recidivism for all six [outcome] measures in comparison to rearrest; (3) reconviction; (4) sex offense reconviction (5) resentence; and (6) revocation of parole/supervised release].

[p.475:] The results for sexual recidivism reveal significant differences between the MnCOSA group and control groups. By the end of June 2017, only one MnCOSA participant (2% of the total) had been rearrested for a new sex offense compared to seven in the control group (14% of the total). The MnCOSA participant rearrested for a sex crime had not been reconvicted for that offense, whereas four of the seven control group offenders had been reconvicted, resulting in a rate of 8% (4 of the control group offenders). All four were resentenced to prison, so the resentence results are the same as those for sex offense reconviction.

The impact of MnCOSA on recidivism

...The results ...show that MnCOSA significantly lowered the risk of sex offense rearrest by 88%. ...The risk of sexual recidivism, for both rearrest and reconviction, was significantly lower for individuals who hand, did not have a significant effect on either sexual recidivism measure.

[p. 479:] **Conclusion**

This evaluation used a small sample size (*N*=100), but the follow-up period for recidivism (average of 6 years) was relatively lengthy. More important, this study used a RCT, which is widely regarded as the 'gold standard' for evaluation research. The results showed that MnCOSA significantly reduced both general and sexual recidivism. Further, the magnitude of this reduction was relatively large, for MnCOSA decreased the risk of rearrest for a new sex offense by 88% and the risk of general recidivism by 49-57%. Due in no small part to these large effect sizes for recidivism, MnCOSA has benefits, with a B/C ratio of $3.73 and produced $40,000 per participant.

[p. 480:] The CoSA model has been difficult to implement in the USA and, even when it has been, a great deal of patience is likely needed to see whether its impact on sexual recidivism ever comes to fruition. Still, there are a number of important lessons we can learn from this evaluation that apply more broadly to correctional research, policy, and practice.

First, to a large extent, MnCOSA has delivered on the promise of 'no more victims.' The results presented here offer the strongest evidence to date the CoSA model can be effective in reducing sexual recidivism. Even if these results are overly optimistic and eventually taper off over time, the effect size would likely still be larger compared to effective interventions such as sex offender treatment (Schmucker and Lösel 2015). ...The evidence presented here suggests MnCOSA is not only effective in reducing sexual recidivism but it may also be more cost-effective than other interventions such as sex offender treatment.

[p. 481:] Second, ...MnCOSA has been cost-effective because it has produced large this study than it did in the initial evaluation (Duwe 2013), due primarily to MnCOSA's impact on sexual offending – the second-costliest type of crime to society.

Third, the improvement in sexual recidivism results from the initial evaluation to this study underscores the importance of applying CoSA to a high-risk population.

...Applying CoSA to a high-risk population thus helps highlight its ability to reduce recidivism."

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B4QR Brings Clarity

Dispelling Misconceptions

B4QR Review: *Wurtele, S.K.*, "'They're Not Monsters!' Changing University Students' Perceptions of Child Sex Offenders through

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Education and Contact," (*Journal of Criminal Justice Education*: https://doi.org/10.1080/1-511253.2021.1892159 [2021]), 1(3) *B4U-ACT Quarterly Review* 12-16 (Summer 2021).

Review Excerpts: [p. 12:] "...The study's rationale for destigmatization is clearly the prevention of child sexual abuse. ...Citing a number of studies, the author argues that prevention efforts are hampered by inaccurate and extremely negative public and professional perceptions of 'child sex offenders (CSOs)' which potentially increase risk factors for offending and reduce the accessibility of treatment.

[pp. 12-13:] The study involved 162 undergraduate students, 85% female, with a mean age of 21.7, almost all of whom majored in either psychology or criminal justice. ...Students read literature on typologies of child sexual offenders, the diagnostic criteria for Pedophilic Disorder, and material from experts and MAPs posted on the Virtuous Pedophile website. Students debated whether pedophilia is a sexual orientation, attended presentations on human trafficking and internet crimes against children, and interacted with mental health and law enforcement professionals who worked directly with people convicted of child sex crimes. According to the author, these professionals 'emphasized seeing the human behind the sex offender label' (p. 207). Students also viewed the movie *Doubt* and the British documentary *The Paedophile Next Door*, discussed how the media plays a central role in public perceptions of CSA and CSOs, and read about the history and consequences of sex crime legislation. Importantly, they also engaged in face-to-face conversations with men convicted of child sex crimes and their therapist.

Monster

[p. 13:] Participants in the study were measured, both at the beginning and at the end of the study, using the author's 'Attitudes toward Child Sex Offenders' scale. Along with items based on the course, where were also items adapted from other scales and surveys designed to measure attitudes and perceptions of people who had committed sex crimes. Four areas were assessed:

- 'Knowledge and myths about CSOs' (p. 205)' This area actually included not only items about the characteristics of people who had committed child sex crimes, but also statements about the nature of such crimes in general and a few items abut MAPs.
- 'Affect-based judgments and interest in associating with CSOs' (p. 205). This included items such as 'CSOs need affection and support just like anybody else,' and 'I would like working professionally with CSOs' (p.206).
- 'Attitudes toward treatment.' This included statements such as 'treatment for CSOs is ineffective,' and 'CSOs should remain in prison for their whole life,' and 'Convicted CSOs can live safely in a community without posing a threat to children' (p. 206).

[p. 14:] Another point to raise ...pertains to the operationalization of the concept of 'treatment.' More specifically, it is unclear what the concepts of 'treatment' and 'rehabilitation,' which the author juxtaposes to punitiveness and the criminal justice system, actually entail. This is crucial, as the line between so-called rehabilitative and so-called punitive approaches can be very thin, with 'treatment' many times functioning as yet another form of (additional) punishment.

Upon analyzing the data gathered from administering the survey at the beginning and end of the course, the author found large and statistically significant increases in scores in all four areas. The increases in two of them were especially large: 'Knowledge and myths about CSOs' and 'Attitudes toward treatment. Even though the 'knowledge and myths area was not limited to stigmatizing beliefs toward those committing child sex crimes, a correlational analysis found that students with more knowledge in this area 'showed more positive affective responses and willingness to associate with CSOs, along with positive attitudes toward sex offender treatment and rehabilitation and reduced support for punitive sentencing policies' (p. 210).

Not a Monster

[pp. 14-15:] At the end of the course, students were also asked to provide their opinion about the videos and invited speakers. A large majority (77%) rated the panel of men who had committed child sex crimes as 'incredibly valuable.' High ratings were significantly related to high scores on 'Affect-based judgments and interest in associating with CSOs,' reduced support for punitive sentencing, and positive attitudes toward treatment. The author writes: 'Findings support the powerful humanizing impact of having direct contact with members of the stigmatized group' (p. 211). This is similar to findings from studies of interventions designed to destigmatize MAPs.

[p. 15:] The author makes the important observation that prevention efforts 'need to move from individual-level activities to systematic strategies aimed at changing macrosystem characteristics including public stigma and legislation' and must involve 'challenging public dehumanization of individuals who have committed CSA' (p. 212). This perhaps lies at the core of promoting effective, just, and humane responses to both MAPs and individuals who have committed child sex crimes."

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B4QR Add-On: Further Clarifying Concepts

B4QR Review: "Supplement to *Wurtele et al.*, "'They're Not Monsters!' Changing University Students' Perceptions of Child Sex Offenders through Education and Contact," p. 12, *supra* (*Journal of Criminal Justice Education*: https://doi.org/10.1080/1-511253.2021.1892159 [2021]), 1(3) *B4U-ACT Quarterly Review* 30-36 (Summer 2021).

Review Supplement Excerpts: [p. 31:] "...[M]any of the methods used in treatment programs for adults and juveniles who commit child sex crimes are extreme and qualitatively different compared to those offered to adults or juveniles who abuse or harm children in nonsexual ways, and they appear to be therapeutically and ethically much more problematic. Such methods include polygraph testing, extreme emphasis on repeated disclosure of all past illegal or harmful behaviors in excruciating detail, as well as on patterns of defective thoughts and feelings, and regular reporting and monitoring of feelings and fantasies. Helping people who have abused children take responsibility for their actions and understand the harm they have caused is essential, but taking this to extremes could arguably contribute to dehumanization and intense psychological harm including self-hatred, depression, and suicidality. It is also noteworthy that such invasive measures (including those mentioned previously, but also others, like penile plethysmography), would be considered unimaginable and abusive in other contexts, but suddenly appear as intelligible and are readily accepted when it comes to sex offenders and 'sexually deviant' persons more broadly.

Such extremes do appear to be quite common. One example is Kahn (2011), a popular 370-page workbook for use by adolescents between 12 and 18 years old who have committed sex crimes. Throughout much of the workbook, youths are presented with detailed and graphic descriptions of abusive sexual behaviors, as well as long lists and categories of selfish and irresponsible thinking patterns, grooming behaviors calculated to lead to sexual victimization, threatening behaviors intended to gain victim compliance and enforce silence, and acts and thoughts leading to the repetition (cycle) of sexually abusive behaviors. The youth are required to meticulously identify, classify, describe, and analyze all examples of these in their own lives. In the process, they must repeatedly describe all of their victims, their sexual behaviors with them (sometimes in sexually graphic detail, including cases of bestiality. Where they must provide the name, sex, and species of every animal they have sexually abused [see p. 76], and how their crimes were discovered. For each victim, they must disclose how often these behaviors occurred, when they began and ended, how they planned their abuse, the grooming behavior they used, any force, bribes, or other means they used, how they felt before, during, and after the incidents, how their victim looked and probably felt during the incidents, the long-lasting effects on each of their victims, their victims' families, and other indirect victims (this is requested repeatedly), and how much responsibility they take for each incident. These questions are not all asked at the same time but rather in many separate exercises over the course of the workbook, so each exercise requires the youth to recount all of their victims. They must complete an extensive analysis of their cycle of abusive behavior, an write a detailed sexual history, including everything they've heard or learned about sex throughout their lives and the circumstances under which they did so. At one point, they are instructed: 'List the sexual experience about which you are most embarrassed and ashamed (such as sex with animals, masturbating with women's underwear, molesting young children, etc.)' [p. 78].

[p. 32:] There is more, but this may suffice to make clear the extreme level of repetition and detail required and the extraordinary emphasis on the youth's patterns of negative behaviors, feelings, and thoughts. It is unclear such extremes are necessary to achieve accountability. There are some exercises on identifying the youth's strengths near the end of the workbook, but they seem overshadowed by the negatively oriented exercises. Such an approach is not seen in treatment for any other kind of behavior involving violence or abuse of children, although it logically could be. There is a chapter on positive sexual expression, however it continues to emphasize the youth's 'unhealthy or inappropriate sexual fantasies' and recommends a form of aversive conditioning to decrease them. Considering this dominant focus on identifying patterns of defective behaviors, thinking, and feelings, it seems difficult to imagine a person would complete such a program without feeling dehumanized and internalizing a perception of themselves and their

(Continued on page 8)

sexuality as permanently defective, dangerous, and shameful. Similar approaches are used on prepubescent children (MacFarlane & Cunningham, 2003; Kahn, 2007).

Perhaps most extreme of all is the electronic measurement of genital responses to 'deviant' sexual stimuli administered by clinicians and aversive conditioning to reduce 'deviant sexual arousal,' both of which appear reminiscent of methods used on gay people 70 years ago.

As of 2009, the most recent year North American treatment programs for adolescents and adults convicted for child sex crimes were surveyed, the penile plethysmograph was used by 31% of those for men and 10% of those for adolescent boys (McGrath et al., 2010, p. 60).

This technology, used in the coercive and adversarial context of the correctional system, requires the adults and adolescents in question to be sexually aroused by exposure to images of children or audio descriptions of sex acts [with them and to have their erections measured by an electronic device.

pp. 32-33:] The use of this technique on juveniles may be decreasing; it was banned in British Columbia after public exposure [illegible] the Association for the Treatment of Sexual Abusers recently recommended against using plethysmographs and polygraphs with juveniles, noting that the 'include the poten- [illegible] adolescent clients' (Association for the Treatment of Sexual Abusers, 2017, p. 34).

However, ethical issues surrounding the use of such technology on adults seem not to be of concern to the profession yet, and its past use on both adolescents and adults may have contributed to their perception that they are seen as less than human.

The survey mentioned above also found that in the U.S., 67% of programs for men, 58% for adolescent boys, 56% for women, and 51% for adolescent girls used 'behavioral sexual arousal techniques' such as covert sensitization, odor aversion therapy, masturbatory satiation, aversive behavioral rehearsal, minimal arousal conditioning, and orgasmic conditioning (McGrath et al., 2010, p. 73).

In the context of the extraordinary societal stigma surrounding 'deviant' sexuality and the adversarial and coercive nature of the legal system mandating this treatment, dwelling not only on previous behavior patterns but also on people's especially intimate feelings (while conceiving of them as 'deviant') could be psychologically destructive, degrading, and dehumanizing, as it was for gay people in the past.

However, there are no guidelines in the literature to aid providers in preventing this treatment from being so, nor any explanations that distinguish it from its prior use on gay people, nor even any recognition that it could be harmful.[5] Such differential and extreme treatment without any recognition of its potential ethical and therapeutic shortcomings can give one the impression that those who commit child sex crimes are seen by professionals as undeserving of the therapeutic standards, ethical principles, and human rights granted to other people, including other types of criminals.

Such extreme approaches seem to be justified by the belief that sexual abuse is far more harmful and pervasive than all other forms of abuse. However, literature suggests that physical and emotional abuse are no less common or harmful than sexual abuse. All forms of abuse are severely underreported so it is difficult to estimate prevalence, but statistics over the past 25 years have fairly consistently estimated physical abuse to be twice as common as sexual abuse, and psychological or emotional abuse (considered the most difficult to detect) to range from slightly less common than sexual abuse to several times as prevalent.[6]

[p. 34:] Moreover, a significant body of research has found emotional abuse and neglect to be on average at least as harmful as sexual abuse.[7] In its release of one such study, the American Psychological Association (APA) wrote that children subjected to psychological maltreatment (bullying, terrorizing, coercive control, severe insults, debasement, threats, overwhelming demands, shunning and/or isola- [illegible] stress and suicidality at the same rate and, in some cases, at a greater rate than children who were physically or sexually abused. [illegible] associated with depression, general anxiety disorder, social anxiety disorder, attachment problems and substance abuse. Psychological maltreatment that occurred alongside physical or sexual abuse was associated with significantly more severe and far-ranging negative outcomes than when children were sexually and physically abused and not psychologically abused, the study found.

Moreover, sexual and physical abuse had to occur at the same time to have the same effect as psychological abuse alone on behavioral issues at school, attachment problems and self-injurious behaviors, the research found.'[8] The APA went on to note that 'psychological abuse is rarely addressed in prevention programs or in treating victims,' adding that the American Academy of Pediatrics has identified emotional abuse and emotional neglect as 'the most challenging and prevalent form of child abuse and neglect,' accounting for 36% and 52% of identified child maltreatment cases, respectively.

Similarly, Dye (2020) found that 'those who reported emotional abuse had higher scores for depression, anxiety, stress, and neuroticism personality compared to those who reported only physical, only sexual, or combined physical and sexual abuse,' and concluded from a brief review that 'studies show emotional abuse may be the most damaging form of maltreatment causing adverse developmental consequences equivalent to, or more severe than, those of other forms of abuse.'

Obviously, nothing is to be gained from a contest to determine which form of abuse is the most harmful or most common. All forms should be targeted with equal dedication, but inaccurately treating one of them as uniquely pernicious and pervasive, and those who commit it as uniquely depraved, is not only counterproductive from a child protection perspective, but also tends to a severe risk of dehumanizing adults and juveniles who commit that form of abuse, in effect justifying and encouraging another form of abuse.

[pp. 34-35:] At the macrosystem level, for the purpose of reducing problematic attitudes toward adults and juveniles who had committed child sex crimes, it may be enormously productive for professionals in the field of sex abuse prevention to adopt language, policies, public education approaches, and treatment methods that are more in line with the best methods used to address physical and emotional abuse and neglect. They should comprehensively and critically examine their practices to ensure they do not pose a risk of dehumanization and psychological harm that is higher than that posed by the practices of those who work to combat physical and emotional abuse.

[p. 35:] Like researchers and educators [illegible] their work in the context of efforts to combat all forms of abuse. For example, like many articles about sex abuse prevention, the article from Wurtele reviewed in this journal [illegible] 'wide-ranging negative consequences …for child victims, communities, and societies' (Wurtele, 2021, p. 201). Neglecting to point out that the same is equally true for other forms of child abuse (as is done in the previously cited studies of emotional abuse) [9] can reinforce the false and harmful view that sexual abuse is uniquely pernicious and endemic and justified more extreme approaches to combat it.[10]

Additionally, Wurtele teaches a 'Sex Crimes Against Children' course; if her university does not offer corresponding courses on physical abuse and emotional abuse, students may gain the impression that sexual abuse is singled out because it is much more harmful and pervasive that other forms of abuse. It would also be productive for studies like Wurtele's to address this common misconception.

Finally, justifying stigma reduction efforts only on the basis of preventing sexual abuse (as the Wurele study does), without also predicating them on the full humanity and inherent worth of MAPs and people convicted of child sex crimes, reinforces their very stigmatization. Wurtele rightly notes that the press frequently dehumanizes 'CSOs,' implying they are non-human and undeserving of human rights. However, we suggest that it may be just as important and remarkably effective (and possibly easier) to step up efforts to address this problem as it exists in the professional practices of forensic psychology and sexual abuse prevention.

Excerpt Notes:

4 See: https://bc.ctvnews.ca/peter-meter-sex-testing-should-stop-watchdog-1.631801 & https://www.cbc.ca/news/canada/british-columbia/penile-tests-of-young-sex-offenders-invasive-report-1.1070849.

5 Thibault et al. (2015) and McPhail & Olver (2020) review the literature to argue that these methods were effective with adolescents and adults, but do not address the possibility of harm or ethical breaches other than the latter article briefly admitting that 'the negative side effects of these interventions are unknown.' The only articles on the ethics of these techniques found in an online search (e.g., 'ethics of aversive conditioning,' 'ethics of arousal conditioning') referred to their use for addictions as controversial and pointed out that professional organizations consider their past use on gay people to be dangerous or abusive, due in part to the severe psychological harm that often resulted. No mention was made of their common use with juveniles and adults who have committed child sex crimes.

6 Spinazzola et al. (2014) includes a review of the literature on prevalence and cites evidence that emotional abuse may be the most underreported type of abuse. More statistics can be found at [illegible] books/NBK195982/, and https://www.acf.hhs.gov/cb/resarch-data-technology/ statistics-research/child-maltreatment.

7 Spinazzola et al. (2014) includes a [illegible] releases/2014/10/psychological-abuse.

9 Both Spinazzola et al. (2014) and Dye (2020) begin by noting the severe harm of all kinds of abuse and trauma without singling out emotional abuse, the subject of their studies. The former begins, 'Nearly 3 million U.S. children experience some form of maltreatment annually, predominantly perpetrated by a parent, family member, or other adult caregiver,' and the latter begins, 'Research shows that early childhood trauma can significantly alter a child's normal development which can cause long-term impairments, even into adulthood.'

10 This false impression is also given by McPhail & Olver (2020) in their review supporting aversive arousal conditioning, whose very first sentence reads: 'The sexual abuse of children has wide-ranging adverse psychological, health, and financial impacts on victims and society.'

Excerpt References: [p. 36:]

Association for the Treatment of Sexual Abusers. (2017). Practice Guidelines for Assessment, Treatment, and Intervention with Adolescents Who Have Engaged in Sexually Abusive Behavior. Beaverton, OR: Author.

Dye, H.L. (2020). Is Emotional Abuse as Harmful as Physical or Sexual Abuse? *Jour. of Child & Adolescent Trauma* 13, 399-407. doi:10.1007/s40653-019-00292-y.

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MacFarlane, K. & Cunningham, C. (2003). *Steps to Healthy Touching: Activities to Help Kids Understand and Control Their Problems with Touching*. Indianapolis: Kidsrights.

McGrath, R.J., Cumming, G.F., Burchard, [illegible] Safer Society Press.

McPhail, I.V. & Olver, M.E. (2020). Interventions for pedohebephilic arousal in men convicted for sexual offenses against children: A meta-analytic review. *Criminal Justice and Behavior*, *47*, (1), 1-21.

Spinazolla, J., Hodgdon, H., Liang, L.-J., Ford, J.D., Layne, C.M., Pynoos, R., Briggs, E.C., Stolbach, B., & Kisiel, C. (2014). Unseen wounds: The contribution of psychological maltreatment to child and adolescent mental health and risk outcomes. *Psychological trauma: Theory, Research, Practice, and Policy*, *6* (Suppl. 1), S18-S28.

Thibault, F. Bradford, J.M.W., Briken, P., De La Barra, F., Habler, F., Cosyns, P. (2015). *The World Federation of Societies of Biological Psychiatry* guidelines for the treatment of adolescent sexual offenders with paraphilic disorders. *The World Journal of Biological Psychiatry*. Doi: 10.3109/15622975.2015.108559.

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Pedophiles Speak: Want to Solve a Problem? Try Listening.

Jill S. Levenson & Melissa D. Grady, "Preventing Sexual Abuse: Perspectives of Minor-Attracted Persons About Seeking Help," 31(8) *Sexual Abuse* 991-1013 (2019)

Text excerpts:

p. 992: "…On their website, [B4UAct, 2018] defines MAP: 'We use the term to refer to adults who experience feelings of preferential sexual attraction to children or adolescents under the age of consent.'

Pedophilia is described as an exclusive or primary sexual attraction to prepubescent children in the …*DSM-5*, and carries with it a great deal of stigma in our society (*Imhoff*, 2015; *Jahnke*, 2018; *Jahnke & Hoyer*, 2013; *Jahnke, Imhoff & Hoyer*, 2015).

won't offend. I need help coping with the life-sentence of being alone with no companion, no one to love, no one to cherish, and give my life to. I want the same thing everyone else wants. But through no fault of my own, I can't have that. Guess I need help with being bitter, as well.'

[Another stated:]

'…I am convinced that my primary [pedophilic] attraction is fixed. I need more help in learning how to cope with accepting myself as I am.'

[Some pedophiles interviewed] identified sexual frustration, along with sadness about the lack of opportunities for sexual gratification and unhealthy coping strategies such as drug or alcohol use, as topics of concern.

p. 1008: …[S]ocial isolation and lack of intimacy can be a risk factor for offending. 'Until then, many individuals with pedophilic preferences remain standing at the edge of society, waiting for self-regulation to fail' (*Houtepen et al.*, 2016, p. 63)."

References:

[illegible] Sexual Development, Coping with Forbidden Feelings, and Relieving Sexual Arousal in Self-Identified Pedophiles," *Jour. Of Sex & Marital Therapy*, 42, 48-69 (2016)

Imhoff, R., "Punitive Attitudes against Pedophiles or Persons with Sexual Interest in Children: Does the Label Matter?", *Arch. of Sexual Behavior*, 44, 35-44 (2015).

Jahnke, S., "The Stigma of Pedophilia," *European Psychologist*, 23, 144-153 (2018).

Jahnke, S. & Hoyer, J., "Stigmatization of People with Pedophilia: A Blind Spot in Stigma Research," *Int'l Jour. Of Sexual Health*, 25, 169-184 (2013).

Jahnke, S., Imhoff, R. & Hoyer, J., "Stigmatization of People with Pedophilia: Two Comparative Surveys," *Arch. of Sexual Behavior*, 44, 21-34 (2015).

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For the Good of All: Embrace the Morals of Humanism

Paul Kurtz, The Affirmations of Humanism: A Statement of Principles, 42(6) *Free Inquiry* 2 (Oct./Nov. 2022)

Editor's Introduction: Although originating in the atheistic movement advocating freedom from religion, "humanism" is actually merely a method of expressing universal moral principles that can and should be applied by all human being without limitation. Yet it derives many of its principles from the noblest and most salutary (for all humanity) of the tenets drawn forth from many religions. Properly understood, it does not conflict with or offend any system of spiritual beliefs.

The following humanistic principles are not limited only to any specific groups or circumstances. These principles serve as a guide and encouragement to all to better themselves and human society at the same will recognize, people who feel better behave better and feel better about doing so.

So, both for people who have violated the rights of others in the past and those who have not, but who recognize that universal inclusiveness is the key to success of humanity, we present these principles and urge *all* to walk in the illumined path they provide.

Text: "We are committed to the application of reason and science to the understanding of the universe and to the solving of human problems.

We deplore efforts to denigrate human intelligence, to seek to explain the world in supernatural terms, and to look outside nature for salvation.

We believe that scientific discovery and technology can contribute to the betterment of human life.

We believe in an open and pluralistic society and that democracy is the best guarantee of protecting human rights from authoritarian elites and repressive majori- separation of church and state.

We cultivate the arts of negotiation and compromise as a means of resolving differences and achieving mutual understanding.

We are concerned with securing justice and fairness in society and with eliminating discrimination and intolerance.

We believe in supporting the disadvantaged and the disabled so that they will be able to help themselves.

We attempt to transcend divisive parochial loyalties based on race, religion, gender, nationality, creed, class, sexual orientation, or ethnicity and strive to work together for the common good of humanity.

We want to protect and enhance Earth, to preserve it for future generations, and to avoid inflicting needless suffering on other species.

We believe in enjoying life here and now and in developing our creative talents to their fullest.

We believe in the cultivation of moral excellence.

We respect the right to privacy. Mature adults should be allowed to fulfill their aspirations, to express their sexual preferences, to exercise reproductive freedom, to have access to comprehensive and informed health care, and to die with dignity.

We believe in the common moral decencies: altruism, integrity, honesty, truthfulness, responsibility. Humanist ethics is amenable to critical, rational guidance. There are normative standards that we discover together. Moral principles are tested by their consequences.

We are deeply concerned with the moral education of our children. We want to nourish reason and compassion.

We are engaged by the arts no less than by the sciences.

We are citizens of the universe and are excited by discoveries still to be made in the cosmos.

We are skeptical of untested claims to knowledge, and we are open to novel ideas and to theologies of despair and ideologies of violence and as a source of rich personal significance and genuine satisfaction in the service to others.

We believe in optimism rather than pessimism, hope rather than despair, learning in the place of dogma, truth instead of ignorance, joy rather than guilt or sin, tolerance in the place of fear, love instead of hatred, compassion over selfishness, beauty instead of ugliness, and reason rather than blind faith or irrationality.

We believe in the fullest realization of the best and noblest that we are capable of as human beings."

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Board Members Sought: Must Have Sincere Compassion

MN Dept. of Human Services, News Release: Behavioral Health Care System Seeks Board Members (July 22, 2024)

five board of Minnesota's state-operated behavioral health care system.

Known as Direct Care and Treatment, or DCT, the system serves more than 12,000 patients and clients each year at psychiatric hospitals and other inpatient mental health facilities, substance-use disorder treatment facilities, special care dental clinics and group homes for people with disabilities.

Currently part of the Minnesota Department of Human Services, DCT will become a separate state agency on July 1, 2025. A nine-member executive board and a chief executive officer will oversee the new agency.

Governor Tim Walz will appoint six board members. The panel will also include the commissioner of the Minnesota Department of Human Services and two non-voting members, one appointed by the Association of Minnesota Counties and one jointly appointed by labor unions representing DCT staff."

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Office of the Minnesota Secretary of State Steve Simon, "Board/Commission: Executive Board of Direct Care and Treatment" https://commissionsandappointments.sos.state.mn.us/Agency/Details (July 27. 2024)

Text with Editorial Clarification: …"The overall management and control of DCT is vested in the executive board to include confirming the overall strategic direction for DCT, establishing policies and procedures to govern the agency, review and approve the operating budget, manage the DCT Chief Executive Officer, and recommend policy changes, DCT operating budget, and capital investment requests to the MN Management and Budget, Governor's Office, and the legislature to carry out the principles and improve performance of DCT.

(a) The DCT executive board consists of nine members with seven voting members and two nonvoting members. The seven voting members must include six members appointed by the governor with the advice human services or a designee. The two nonvoting members must be appointed in accordance with paragraph (c)….

(b) The executive board voting members appointed by the governor must meet the following qualifications:

(1) One member must be a licensed physician who is a psychiatrist or has experience in serving behavioral health patients.;

(2) two members must have experience serving on a hospital or nonprofit board; and

(3) three members must have experience working: (i) in the delivery of behavioral health services or care coordination or in

(Continued on page 10)

traditional healing practices; (ii) as a licensed health care professional; (iii) within health care administration; or (iv) with residential services.

(c) The executive board nonvoting members must be appointed as follows:

(1) one member appointed by the Association of Counties; and

(2) one member who has an active role as a union representative representing staff at Direct Care and Treatment appointed by joint representatives of the following unions: American Federation of State, County and Municipal Employees (AFSCME); Minnesota Association of Professional Employees (MAPE); Minnesota Nurses Association (MNA); Middle Management Association (MMA); and State Residential Schools Education Association
clude representation from outside the seven -county metropolitan area, defined in section 473.121, subdivision 2 [of Minnesota Statutes] must not be or must not have been within oine year prior to appointment: (1) an employee of Direct Care and Treatment; (2) an employee of a county, including a county commissioner; (3) an active employee or representative of a labor union that represents employees of Direct Care and Treatment; or (4) a member of the state legislature. This paragraph does not apply to the nonvoting members or the commissioner of human services or designee.

Executive board members must recuse themselves from discussion of and voting on an official matter if the executive board member has a conflict of interest. A conflict of interest means an association, including a financial or personal association, that has the potential to bias or have the appearance of biasing an executive board member's decision in matters related to Direct Care and Treatment or the conduct of activities under this chapter.

The initial appointments of the members of the Direct Care and Treatment executive board under Minnesota Statutes, sec. 246C.06, must be made by January 1, services, executive board members must not serve more than two consecutive terms unless service beyond two consecutive terms is approved by the majority of voting members. The commissioner of human services or a designee shall serve until replaced by the governor.

An executive board member may resign at any time by giving written notice to the executive board.

The initial term of the member appointed under subdivision 2, paragraph (b), clause (1), is two years. The initial term of the members appointed under subdivision 2, paragraph (b), clause (2), is three years. The initial term of the members appointed under subdivision 2, paragraph (b), clause (3), and the members appointed under subdivision 2, paragraph (c), is four years.

After the initial term, the term length of all appointed executive board members is four years.

Chief executive officer

The Direct Care and Treatment executive board must appoint as the initial chief executive officer for Direct Care and Treatment ...the chief executive officer of the direct care and treatment division of the Department of Human Services holding that position at the time the initial appointment is made by the board. The initial appointment of the chief executive officer must be made by the executive board by July 1, 2025. The initial appointment of the chief executive officer is subject to confirmation by the senate....

Entity Powers and Duties, Activity Summary

The executive board is authorized to adopt, amend, and repeal rules in accord-
this chapter or any responsibilities of Direct Care and Treatment specified in state law.

Until July 1, 2027, the executive board may adopt rules using the expedited rule-
orders, rules, delegations, permits, and other privileges issued or granted by the Department of Human Services with respect to any function of Direct Care and Treatment and in effect at the time of the establishment of Direct Care and Treatment shall continue in effect as if such establishment had not occurred. The executive board may amend or repeal rules applicable to Direct Care and Treatment that were established by the Department of Human Services in accordance with chapter 14.

The executive board must not adopt rules that go into effect or enforce rules prior to July, 1, 2025.

The Direct Care and Treatment executive board ...shall establish an advisory committee to provide state legislators, counties, union representatives, the National Alliance on Mental Illness Minnesota, people being served by direct care and treatment programs, and other stakeholders the opportunity to advise the executive board regarding the operation of Direct Care and Treatment. The executive board shall regularly
immune from civil liability for any act or omission occurring within the scope of the performance of their duties under this chapter [Statutes, Ch. 246C].

When performing executive board duties or actions, members of the executive board are employees of the state for purposes of indemnification under section 3.736, subdivision 9 [of the Statutes]....

At the first meeting of the executive board, the executive board must elect a chair from among the voting membership appointed by the governor.

The executive board must annually elect a chair from among the voting membership appointed by the governor.

The executive board must elect officers from among the voting membership appointed by the governor. The elected officers shall serve for one year.

The executive board must meet at least four times per fiscal year at a place and time determined by the executive board.

The majority of the voting members of the executive board constitutes a quorum. The affirmative vote of a majority of the voting members of the executive board is necessary and sufficient for action taken by the executive board.

Name	Position	Application date
Dr. Paul Goering, MD	Licensed Physician who is a Psychiatrist or has Experience in Serving Behavioral Health Patients	7/23/2024
Dr. Joel Strauch	" "	7/23/2024
Todd Archbold	Members with Experience Serving on a Hospital or Nonprofit Board	7/24/2024
Sally Macut	" "	7/24/2024
Mary Maertens	" "	7/24/2024
Zamzam Ahmed	Members with Experience ((i) in the delivery of behavioral health services or care coordination or in traditional healing practices; services or care coordination or in traditional healing practices; (ii) as a licensed health care professional; (iii) within health care administration; or (iv) with residential services.)	7/24/2024
Chris Beamisch	" "	7/23/2024
Christina Bourland	" "	7/10/2024
Molly Gilbert	" "	7/23/2024
Angela Hansen	" "	7/23/2024
Kalene Haugen	" "	7/22/2024
Faith I. Brown	" "	7/22/2024
Victoria Incorporated)	" "	7/22/2024
Kathryn Kallas	" "	7/26/2024
Zoey Martin	" "	7/22/2024
Melissa Mikkonen	" "	7/22/2024
Abigail Morgan	" "	7/24/2024
Carl W. Mothes	" "	7/22/2024
Erin Pash	" "	7/22/2024
Brettina Phillips	" "	7/24/2024
Jason Porter	" "	7/26/2024
Holly Rien	" "	6/17/2024

Applicants (25):

No pending appointments found.

Meeting Information

...Meeting frequency: At least once a quarter (every three months).

Meetings are held at:

3200 Labore Road, Suite 104, Vadnais Heights, MN 55127. Some trainings and meetings may be virtual."

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Editorial Note: All applicants for appointment to the DCT executive board known at time of this writing are listed above. Those readers who are able and feel inclined to investigate such candidates for public office are encouraged to do a little checking into which of these individuals, if appointed, can be expected to treat us favorably and reasonably, and which cannot. Your prompt report of your findings will be welcomed with special gratitude by Cyrus P. Gladden II.

* * * * * * * * * *

the Legal Pad

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