

"...[T]hose who raise walls will end up as slaves within the very walls they have built." – Pope Francis, Encyclical: Fratelli Tutti (2023)

In This Issue:

1. Who Knew What When? Troubling Questions of False Appearances	1-9
2. Reports Confirm MSOP Failing Performance.	9
3. No Public Official Is Above the Law.	9
4. MSOP Provisional Release - Hyper-Restriction, Waste, & Why SRB-CAP Process Can Only Drag Feet.	9-10
5. If: Advice as Good Now as Then.	10

Coming Soon:

- ✓ Are Effective Counsel/No Counsel Your Rights in SOCC Cases?
- ✓ Community Notification: A Shock-Show That Harms Its Audience?
- ✓ Sex Offender Residence and Employment
- ✓ What Does Barring Inter-SO Associations Actually Result in?
- ✓ Remorse Bias — What's THAT?!
- ✓ RNR vs. Good Lives vs. Virtue Ethics vs. Desistance
- ✓ Blanket Exclusions of SOs
- ✓ Banishment by 1000 Laws
- ✓ Levenson on Needs-Preferences of Clients of SO Treatment
- ✓ 'New' SORN Laws Are Punitive
- ✓ SO Reintegration - Environmental Factors Must Be Considered
- ✓ Different Backgrounds: Different Perceptions of SO Policies
- ✓ Perlin Sounds Off
- ✓ NIMBY: Not the Latest Toy Robot
- ✓ Legislative Testimony by the Confined
- ✓ PPG Test Results – Inadmissible
- ✓ What IS Rehabilitation When It Is Said to Differ for Sex Offenders?
- ✓ Moral vs. Clinical Decisions
- ✓ Guessing the Number of Unreported Sex Crimes Is Not Science.
- ✓ Why the AI Black Box Doesn't Know Why It Condemns You; It Just Does.
- ✓ Pedophiles in UK Communities
- ✓ What Is The Mandela Effect, and Why You Should Care
- ✓ Are Internet Bans Sinking Like the Titanic?
- ✓ Algorithmic Risk Assessment assessed
- ✓ Your First Amendment Rights in SOCC
- ✓ Protecting Children from Sex Crimes – AI-Driven, Child-Simulacron Robots
- ✓ Legislative Testimony—Truth to Power for Real
- ✓ Evidence to Undermine Statutes as a Due Process Right
- ✓ Confrontation Denied by 'Relayed' Expert Opinion Statements
- ✓ Assassination of Legislators, Terrorizing Advocates: Tools of Oppressors
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Baldrige Comes to MSOP – But Why ?

by Cyrus P. Gladden II, J.D.

This is the story of how MSOP, a miserably unqualified, mostly *non*-performing sex offender treatment program operating in the context of a "shadow prison" for those under civil commitment after they have completed their (typically decades-long prison terms), was given a "Baldrige Award" claimed to be for a level of "performance excellence."

It is also a story in part about how those awards, largely impressionistic, are granted, the potential for deception on the part of those with something to gain if such an award is received, and strong questions of ethical violations on the part of Baldrige Award insiders when such awards are received by business or governmental entities headed or overseen by such insiders.

And in the end, most important of all, it is a story about human lives being doomed to be spent in such 'shadow' supplemental imprisonment by procuring such undeserved awards for MSOP despite its many failures and its false excuse-claim: that past sex offenders under treatment there are so difficult to treat that treatment durations, instead of being the 2-3 years elsewhere, must be the 20-years and more of indefinite imprisonment MSOP applies. This omits to state that MSOP's divergent treatment regimen was designed expressly and solely for MSOP to take all those extra years, for the apparent purpose of simply delaying, perhaps permanently blocking release -- even just to an intensive parole afterward.

This is not a temporary glitch; after 30 years of MSOP operation, the intentionality of this deliberate foot-dragging in the delivery of treatment appears quite undeniable. Its ordaining reality is best counted out by comparing the 108 individuals who died in MSOP confinement, either while struggling mightily to qualify for release, or after finally giving up. I have seen those thus abandoning hope, slipping under the waves of fatal futility like drowning men at sea when exposure and exhaustion have taken their final toll. I know this; I have seen a couple die; I have comforted numerous others in their last days, and I have tolled that sailors' bell in my mind with each entry I have been forced to add to my list -- with 750 more still alive and trapped in this confinement after as many as 30 years, many already of advanced age. At age 74, I count myself in this last echelon of life. In contrast, less than 30 former MSOP confinees are now living in freedom after "final discharge" -- a status typically taking five years or more after "provisional discharge" to attain.

This is a story of captors and even those therapists who claim to be trying to hurry the onerous and time-consuming treatment along, but in reality constrained by their superiors who veto even such acts aimed toward providing at least a little efficiency. Thus, taken altogether, this reality reeks of contempt for the humanity of their captives. It is also a story of practices deeply caught in the concrete of the biased -- but utterly false -- belief that even former sex offenders whose last sex crime occurred 20, 30, 40 or even 50 or more years ago are supposedly as danger-

ous now as if that crime occurred just yesterday -- and the even more ludicrous belief that even old former sex offenders -- as old as age 70 or beyond -- are just as dangerous now as they were claimed to be when they were in their 20s. This is not punishment; the underlying sentences have in most cases expired long ago. Instead, it is denial of the fundamental right to liberty guaranteed by the Fourteenth Amendment to the U.S. Constitution on nothing more than disproven hysterical myths and baseless but abiding suspicions of still-abiding criminal intents long after all such wishes have long ago guttered out like exhausted candles.

Allow a brief digression here to make a point about how widespread the knowledge is that MSOP, in all but its own empty claims, is just an indefinite (likely, remaining lifetime) supplementary detention device to inflict upon those who have served their full (usually extremely long) prison terms, but whom some wish not to release, whether from baseless fear or from unquenchably rageful categorical hatred:

In this legislative session in Minnesota, a long-time member of the Minnesota Senate, notably a Republican, stated in televised hearing that he could not understand why opponents of MSOP, rather than debating relatively minor matters about MSOP, did not simply formally propose repeal of its entire statutory authorization, given that MSOP and that authorization are categorically unconstitutional overall, to the knowledge of the entire Legislature. Not one voice was raised in objection to this assertion.

The point of this digression is to buttress the contention that MSOP either serves a hidden agenda of solely such post-prison detention or fails abysmally at its claimed mission to treat those committed to it and to release them to live in open society. Under either view, MSOP does not even remotely qualify for an award for excellent performance of that openly claimed mission.

Before we proceed any further, we need a primer of sorts on sex offender civil commitment generally and on MSOP in particular. For that purpose, consider the following excerpts from "WSJ Speaks Out Against SOCC & MSOP, but Leaves Too Many Rocks Unturned," *the Legal Pad*, Vol. 7, No. 10, (Oct. 2023), pp. 1-2:

"Daniel Montaldi, 'A Study Of The Efficacy Of The Sexually Violent Predator Act In Florida,' 41 *Wm. Mitchell Law Rev.* 780-865, at 845 (2015). ('...[T]here appears to be no discernible risk-reducing effect coming from progressing in treatment or completing it....', explaining at pp. 862-63, '...With rates as low as they are, even for untreated offenders, it is unlikely that any intervention can significantly lower rates any further. This may reflect a kind of statistical floor effect.' Montaldi, in his studies of recidivism among Florida sex offenders recommended for commitment but nonetheless later released, found that '[t]he most dramatic difference comes from offenders who were age sixty or older at time of recommendation (n=93). Out of this group, no one obtained a new charge or conviction for either rape or child molestation (0%).' *Id.*)

There are no data that support the notion that any kind of current treatment makes any significant difference in recidivism rates of sex offenders once released. (*Anne R. Izzi, 'Constitutional Law – The Cage a Fetish Can Build: Proposed Legislative Reform for Civil Commitment Procedures in Sexually Violent Predator Laws,' 39 Western New England Law Rev.* 141, at 145-46 (2017), states: '...[T]he facilities that do offer treatment are not beneficial because, as of yet, researchers in the field have not found any successful treatment options... [T]he issue is not treatment standards, but rather the current lack of any viable treatment methods in the field of sex offender management.'

When it comes to recidivism, sex offender treatment is purely just a wash. *Thomas K. Zander, 'Civil Commitment without Psychosis: The Law's Reliance on the Weakest Links in Psychodiagnosis,' 1 Jour. Of Sexual Offender Civil Commitment: Science and the Law* 17, at 35 (2005), observes that: 'Research regarding the treatment of sex offenders continues to show that treatment has little or no effect on sexual recidivism rates. It is easy to locate well-controlled studies that find no effect of sex offender treatment on recidivism likelihood. *J.K. Marques, M. Wiederanders, D.M. Day, C. Nelson & A. van Ommeren, 'Effects of Relapse Prevention Program on Sexual Recidivism: Final Results from California's Sex Offender Treatment and Evaluation Project (SOTEP),' 17 Sexual Abuse: A Jour. Of Research and Treatment* 79-107 (2005); *Losel & Schmucker*, 2005). For example, *Hanson, Broom, and Stephenson* (2005) compared the recidivism rates of 403 treated sex offenders to those of 321 untreated sex offenders over a 12-year period and found no significant differences between the two groups as to sexual recidivism, violent recidivism, or general recidivism.'

... Accord: *Marnie E. Rice & Grant T. Harris, 'The Size and Sign of Treatment Effects in Sex Offender Therapy,' 989 Annals N.Y. Acad. Sci.* 428, 428 (2013) ('We conclude that the effectiveness of psychological treatment for sex offenders remains to be demonstrated.'). See also: *Jill S. Levenson et al., 'Public Perceptions about Sex Offenders and Community Protection Policies,' 7 Analyses Soc. Issues & Pub. Pol'y* 1, 6 (2007), avail. at: <http://ccoso.org/library%20articles/PublicPerceptions%20ASAP%207.pdf> (noting that studies have concluded that recidivism rates of those treated and untreated are undifferentiated...)

Research that has shown that other post-release matters make a huge difference in re-offense rates -- notably the phenomenon of "desistance" -- with its promoting circumstances and malleable attitudes of former sex offenders -- are largely ignored, apparently out of political considerations that persist in infiltrating so-called current treatment modalities with punitive elements. See, e.g., *Prof. Danielle Arlanda Harris, 'A Descriptive Model of Desistance from Sexual Offending: Examining the Narratives of Men Released from Custody,' 60(15) Int'l Jour.*

Of Offender Therapy and Comparative Criminology, 1717-1737 (2016); Tulley, Joanne L., "While This Does Not in Any Way Excuse My Conduct....," 60 *Int'l Jour of Offender Therapy & Comparative Criminology* 1776-1790 (Issue 15, November 2016); DOI 10.1177/0306624X.16668177; Farmer, Mark, McAlinden, A.M., & Maruna, S., 'Understanding Desistance from Sexual Offending: A Thematic Review of Research Findings,' 62(4) *Probation Journal* 320-35 (2015); Danielle Arianda Harris, 'Desistance from Sexual Offending: Behavioral Change Without Cognitive Transformation,' *Jour. Of Interpersonal Violence*, 1-22 (2015); Patrick Lussier, 'Desistance from Crime Without Reintegration: A Longitudinal Study of the Social Context and Life Course Path to Desistance in a Sample of Adults Convicted of a Sex Crime,' 60(15) *Int'l Jour. Of Offender Therapy & Comparative Criminology* 1791-1812 (Nov. 2016); Danielle Arianda Harris, *Desistance from Sexual Offending: Narratives of Retirement, Regulation and Recovery*, Palgrave MacMillan (2019).

Nowhere is this more visible than in SOCC facilities, where treatment, even when based on prison programs that are relatively short-term and direct in their focus, becomes an elaborate, endlessly circular affair, needlessly consuming many years, even decades of 'tail-chasing' by treatment participants in response to unnecessary, self-shaming assignments repeatedly demanded by therapists.

The MSOP treatment program, for instance, is based on a unique, homemade theory of personal ideas of earlier program leaders without any research support of 'changes' supposedly required to prevent re-offense. This "Matrix" of 34 requirements of so called 'behavioral change' reads like a strict etiquette rule-book that must be followed exactly minute-by-minute, including self-reporting and self-criticism and criticism by staff and by other treatment participants seeking a leg up for each slip or inadvertent failure of total compliance. This harsh and impossible-to-satisfy system, coupled with often re-demanded 'admissions' (true or merely extorted falsehoods) of still-ongoing drive to commit illegal sexual misconduct amounts to the American Gulag, a Chinese-style "re-education camp" for brainwashing. It is a perfect recipe for keeping every MSOP confinee detained for life, which its original legislative sponsors candidly admitted was its punitive aim.

...[T]he claim of high-risk to reoffend is a massive lie. Earlier statistics that sought to claim a difference in certain sex offenders in terms of probability of future sex offenses have been debunked as deceitful manipulations of sample groups chosen and of statistical techniques to radically skew appearance to create false impressions of high recidivism likelihood where none exists. (See, e.g., Eds., "Webinar - Sex Offense Recidivism Risk: Not What You Think It Is," *CURE-SORT News*, Vol. 31, Issue 3, pp.2-3 (3rd Quarter 2022) ('Better late than never: Static-99R maker debunks myths of high so recidivism risk

capitalized on.')

Some so-called actuarial recidivism tools have been created for this express purpose. See, e.g.: Melissa Hamilton, 'Briefing the Supreme Court: Promoting Science or Myth?', 67 *Emory Law Jour. Online* 2021 (2017) Almost all who have been committed to MSOP have recidivism predictions that do not depart significantly to those of sex offenders passed over for commitment. Actual re-offense rates once released bear this out. MSOP strives to cover this reality up, in order to justify retention in confinement of those committed to it.

...[M]umbo-jumbo treatment theories such as the unique 'Matrix' theory, based on efforts to brainwash individuals to be more polite members of society generally, have no perceptible impact on re-offense probability at any age. In its *Findings of Fact, Conclusions of Law and Order* dated June 15, 2015 in the federal case, *Karsjens et al. v. Harpstead*, the Court rejected the scientific validity of the so-called 'Matrix-Factors' in use in MSOP, observing that they "are not used by any other civil commitment program in the country. MSOP's use of these Matrix Factors has never been validated on a sex offender population. *Karsjens Trial Tr.*, v. 5, p. 1026. Note also Dr. Miner's testimony as to the Matrix:

'Q. Let's talk about the Matrix factors. Do you take any issue with the Matrix factors scoring guide?

'A. Yes.

'Q. And tell me about that.

'A. Well, the Matrix factors scoring guide doesn't meet minimal requirement for a psychological test as promulgated by the joint APA-AERA Guidelines for Psychological and Educational Testing. It doesn't include a lot of information that would be required in a guide or in a manual....

'It's been criticized for being unreliable...' (Trial Tr., v. 6, pp. 1183-84).

More pragmatically, Dr. Cauley testified that the Matrix factors at MSOP are: "... sort of an in-house tool that was developed by members of the - employees at the facility. It serves a purpose perhaps of simply being - I wouldn't say treatment progress, but it's almost like a checklist of really how somebody is participating in treatment. Okay? So it's a lot of 1 to 5 ratings of things like attending groups, participating in group, that kind of thing.

...And it doesn't serve a larger purpose of assessing risk.' (Trial Tr., v. 10, p. 2221). In Findings 83-86, the Court determined that MSOP clinical staff has experienced substantial confusion and inconsistencies in the use and application of the Matrix factors, with Matrix factors scores fluctuating at changes in clinical staffing, such that a lack of inter-rater reliability is presented. (D. McCulloch testimony, Trial Tr. v. 1, pp. 82-83.) Dr. Vietanen put it more bluntly: "...[T]here isn't any inter-rater reliability in Matrix scoring.' (Trial Tr., v. 10, p. 2327). Dr. Nicole Elsen conceded that scoring of the Matrix factors is somewhat subjective. (Trial Tr. v. 7, pp. 1347). Dr. Elsen also admitted that she had, at various times, directed the clinicians under her supervi-

sion in MSOP to lower a given treatment participant's Matrix scores, and that such scores were in fact lowered at her direction. (*Id.*, pp. 1347-48.) Yet Dr. Elsen has never approved phase advancement of any MSOP detainee who has not met the Matrix goal requirements for such advancement. (*Id.*, p. 1348)."

Summing from the foregoing excerpts, of no little moment, at the Metropolitan State University seminar on sex offender commitment and MSOP in March 2024, Jannine M. Hebert, MSOP Executive Clinical Director, Comments at Metropolitan State University, April 2023 Seminar (Run Time: 42:40.), made this revealing admission: "...I am not here to defend civil commitment and in fact I went and took a job at MSOP because I think civil commitment is ridiculous. And I think that change can happen from lots of places.... Sometimes people do it from within...." Verily, *ne plus ultra*.

Bearing the foregoing primer in mind, let us now return to a time in 2023, when MSOP was tasked, as it had been annually by the Minnesota Legislature, to file a publicly available report on its performance during the previous year. That report will be addressed in the immediately following article. However, the Legislature chose to end the requirement for these annual reports, which explains why there has been no such report for 2024 and why there will be no further such annual reports going forward in the future. (Source: "MSOP Inspections by Outsiders & Reports to Legislature End", by Rodger Robb, *the Legal Pad*, vol. 7, No. 7 [July 2023], p. 5).. MSOP received all that it needed to justify its existence by the baseless conclusion by the outside private entity, Performance Excellence Network, proclaiming MSOP's performance to be adequate, as recounted below.

We start our coverage of the award given MSOP by tracing the history of that award program, founded for businesses and government agencies with achievements of particularly effective and efficient performance of the goals and tasks of the entity in question.

Congress established this program through Public Law 100-107, the Malcolm Baldrige National Quality Improvement Act. At first, program operation was conducted by NIST, 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 to more fully fund the program, but this federal funding ended in 2011. Since then, all funding has been private. It would seem probable that such funding now comes from the entities seeking such awards.

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

Program purports to focus 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; and
- Baldrige-based approaches focused on quality jobs, cybersecurity risk management, leadership development, and community excellence.

Showing its focus on criteria that are business-success factors, judging includes, among others, 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." Remember those 108 deaths in MSOP thus far? If performance and success are measured by the rate at which those confined are cleared for return to society, how does a commitment system like MSOP, whose rate of such deaths eclipses the rate at which former confinees are granted final discharge, qualify for such an award?

The Performance Excellence Network (PEN) is a non-profit, membership-driven organization serving entities in Minnesota and the Dakotas. Upon request from an entity, PEN examines its practices and performance and, where this examination shows qualification, gives public recognition by bestowing a Baldrige Award. PEN is one of a number of organizations around the country that are permitted by NIST and the Baldrige Foundation to bestow this honor.

PEN lists only two members of its "team," a President and a person in charge of accounting. It has an 11-person "Governing Board." Among its members is Marshall Smith, the CEO of the State of Minnesota's department-level agency, Direct Care and Treatment. PEN also has regional "advisory boards" in at least three eastern areas of Minnesota.

PEN offers "memberships" to organizations providing a "contribution" (amount not specified in the Membership page of its website). Many of PEN's services are available to both members and non-members, but members are eligible for varying discounts from the standard rates for such services. In its Assessment page, the PEN website cites prices of examination toward the Performance Excellence Award for large-entity members as being roughly \$16,000. PEN Memberships are offered in tiers, with the top level of membership being that of a "Premium Organization." DCT holds this level of membership in PEN. The annual price for this can be as much as \$30,000 for a large organization. DCT, having over 5,000 employees, is the largest

state agency in Minnesota and is likely at the pinnacle of organizational size served by PEN. It should be obvious that DCT therefore is an organization deemed to be most valuable as a member of PEN.

PEN offers such premium member organizations free admittance to its "Baldrige 101" and/or "Evaluator" training. In addition, a 50% discount on enrollment cost is extended to all members for all employees in a member organization for the "Evaluator" training. When read with materials from NIST, this training is apparently equivalent to that which Baldrige evaluators receive. The point is to supply the member organization with the criteria that evaluators will apply before they arrive to conduct their examination. This allows things to be temporarily made to appear to be in fulfillment of Baldrige standards even though they may be out of compliance day-in and day-out.

DCT has received Baldrige examinations in three years (2021-22, and 2024) out of the last four years for five of its sub-entities, including MSOP. Apparently, the cost for examination is figured separately for each sub-entity. Thus, the total cost of all examination fees to gain a Performance Excellence Award for each sub-entity could be as high as \$80,000 each year. These sub-entities of DCT have each received the Baldrige-based Performance Excellence Award in three of those years, perhaps tripling that overall cost to about \$250,000 over four years.

How a failing entity like MSOP can receive a PEN version of a Baldrige award starts to become apparent by reading a blog page by PEN (<https://performanceexcellence-network.org/persights/performance-excellence-network-recognizes-seven-with-award-2/>).

It states that there are actually five levels of a Performance Excellence Award. The top level is for "Excellence" -- what PEN designates as a "role model" organization. However, in descending order, the next-lower levels of the Performance Excellence Award are: Achievement, Advancement, Engagement, and Commitment. MSOP's "Performance Excellence Award" for 2024 was actually only for the "Engagement" level. In other words, the award to MSOP was actually second-lowest in this ranking of awards, far from "Excellence", much less as a "role model" entity.

For years 2021 and 2022, MSOP received only the lowest level, "Commitment." The 2023 PEN award was not awarded to any of DCT's sub-entities specifically, instead awarded to Direct Care and Treatment itself for "advancement" (again, not "excellence") in its administration over all of its sub-entities, with no particular praise for MSOP itself. (See the 2023 sub-page within that same PEN awards blog URL.)

As supervised by the federal government's National Institute of Standards and Technology (NIST), the Baldrige Program requires that all information about organizations receiving Baldrige Award evaluations is held in strict confidence by everyone connected with the evaluation. However, this creates a kind of 'stonewalling' about the facts either supporting or questioning the validity of the award.

Thus, the confidentiality requirements of the award itself which make the necessary data unavailable render effective comparison of the significance of the award impossible. This includes applications, scores, and examiners' evaluations, including of both winners and non-winners.

Award recipients 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 or PEN on such submissions. DCT press releases about PEN awards have never discussed any of the categories judged by PEN in accord with Baldrige formulation.

Whether the application for the Baldrige award was submitted by MSOP or by DCT as its administrative parent on MSOP's behalf, the implication from the fact of that submission while knowing the true state of affairs as to MSOP would appear to be that the application was false or very misleading in substance, given the lack of any meaningful level of results-oriented performance by MSOP. If done in the context of the present controversy about MSOP, it would appear to be to manufacture an invalid argument for MSOP's continued existence and operation in its status quo. In this connection, it will pay *infra* to now pose a metaphorical question: Is there really a pay-off when the slow kid in class, even though failing, is simply complimented for effort and allowed to go on failing?

Before we get into how Baldrige examination applies to MSOP, it pays to understand some of the chief longstanding criticisms of the Baldrige Award, as reported by David A. Garvin, in the *Harvard Business Review* (Nov.-Dec. 1991). First, many winning contestants made enormous investments toward impressing Baldrige examiners. For example, Xerox, (a 1989 winner), spent \$800,000 and 14,000 labor hours, and readied employees for site visits in advance. Such actions have been the basis for claims that "the Baldrige can be bought."

Second, the award does not reflect outstanding or even exceptionally good product or service quality. So for instance, Cadillac, while a Baldrige winner, had not entered the top ranks of most automobile quality surveys. Accordingly, although a Baldrige award might sound impressive to a prospective Cadillac buyer, it held no true significance to such a purchaser.

Distinctly, Baldrige judges may come from industry, academia, or consulting firms; however, the question remains as to what relevance their knowledge and experience may have to a unique mental health commitment program such as MSOP. (Recall that less than 7,000 individuals are currently confined in sex offender civil commitment facilities in total throughout the United States, and that no comparable commitment programs exist in any other country.)

Professor Garvin called a Baldrige Award "something of a Rorschach test, a projective device in which people see what they want to see..." Certainly this applies in the context of judging sex offender treatment programs.

Further, the Baldrige award criteria are open-minded about practices and procedures. Yet rates of release in the three closest states to Minnesota that have sex-offender commitment systems (Wisconsin, North Dakota, and Iowa) are very high, while MSOP's rate is only a trickle. But nothing available to anyone outside of the PEN examiners indicates whether they ever had this fact, or chose to consider it in determining performance by MSOP, so divergent from prevalent precepts and practices in sex offender treatment elsewhere. Without such guiding standards of performance, there is simply nothing to comparatively judge MSOP against.

This is exacerbated by the fact that there are no agreed-upon standards of 'success' when it comes to treating sex offenders. The common goal is to achieve less recidivism. However, differences in how recidivism is measured, plus what is deemed to constitute recidivism and what kinds of recidivism are deemed relevant (or to what relative degree of importance) confound such comparisons. What is known, however, is that recidivism rates by formerly committed sex offenders in those three neighboring states, with comparatively very short confinement periods, are vanishingly low. It is clear that they are doing something right, and MSOP is doing everything wrong. When human lives are on the line, it is ethically criminal not to ask what the differences are, and to implement those differences in MSOP. But the PEN award apparently did not concern itself with any of this.

Most crucially, there is much argument as to whether current modalities of sex offender treatment have any significant impact on sex offender recidivism at all; further, the impact of other concurrent factors that have impact on recidivism remains unknown. See, e.g., *Marnie E. Rice & Grant T. Harris*, "Treatment for Adult Sex Offenders: May We Reject the Null Hypothesis?", Chapter 13 in *The Wiley-Blackwell Handbook of Legal and Ethical Aspects of Sex Offender Treatment and Management*, 1st ed., Karen Harrison & Bernadette Rainey, eds. (John Wiley & Sons, 2013), for application of a rigorous scientific procedure to examine this subject, concluding that there is no clear evidence that treatment of sex offenders has any effect at reducing the likelihood of recidivism. See also: *Gregory DeClue & Denis L. Zavodny*, "This Just In: Sex Offender Treatment Is Beneficial for One in 28 Patients," 17(4) *Sex Offender Law Report* 49-64 (June/July 2016); *Eric S. Janus et al.*, *Sex Offense Civil Commitment: Minnesota's Failed Investment and the \$100 Million Opportunity to Stop Sexual Violence*, *Sex Offense Litigation and Policy Resource Center*, mitchellhamline.edu/sex-offense-litigation-policy, Mitchell Hamline School of Law (April 2024), p. 8. Essentially, the extremely important question that is not being asked is: what are Wisconsin, North

Dakota, and Iowa doing that MSOP is not? Further, the natural phenomenon of eventual complete desistance from crime is now known to build during imprisonment as well as after release and to impact sex offenders far more than other classes of criminals. *Patrick Lussier & Evan McCuish*, "Desistance from Crime without Reintegration: A Longitudinal Study of the Social Context and Life Course Path to Desistance in a Sample of Adults Convicted of a Sex Crime," 60(15) *International Journal of Offender Therapy and Comparative Criminology* 1791-1812 (2016). Thus, for instance, *Daniel Montaldi*, "A Study Of The Efficacy Of The Sexually Violent Predator Act In Florida," 41 *Wm. Mitchell Law Rev.* 780-865 at p. 843 (2015) declares:

"At this point in time, no form of treatment -- inpatient or outpatient -- shows a clearly measurable effect in reducing risk for offenders recommended for commitment in Florida. However, a lack of efficacy does not mean that treatment programming has been poorly designed or administered. It seems more likely that rates for untreated offenders, even those thought by experts to be especially high risk, are already so low that no intervention short of physical incapacitation can reduce rates further, at least not significantly. A kind of statistical 'floor' effect in sexual recidivism may be occurring." (emphasis added). Thus, both desistance and the statistical floor effect pose confounding causes contemporaneous to any effect by sex offender treatment. Again, PEN apparently did not inquire into these matters at all.

The "Key Findings" in the widely hailed Report by the Sex Offense Litigation and Policy Resource Center (SOLPRC) at Mitchell Hamline School of Law, Eric S. Janus, Director, titled: *Sex Offense Civil Commitment Minnesota's Failed Investment and the \$100 Million Opportunity to Stop Sexual Violence* (April 2024) (hereinafter, the "SOLPRC 2024 Report"), p. 1, include these:

- "Among the minority of states that have these laws, Minnesota is an outlier. **Minnesota's SOCC program, called the Minnesota Sex Offender Program (MSOP), has the highest number of civilly committed individuals per capita of any state in the country with one of the lowest rates of discharge.**
- As of September 1, 2023, **only 21 of the 946 people committed to MSOP have been fully discharged from the program (~2%), while at least 94 have died during their commitment (~10%).**
- As of September 19, 2023, **74% (557) of the approximately 747 people detained in MSOP have been there for over a decade**, 48% (364) have been in MSOP for over 15 years, 18% (138) have been detained for over two decades, and 8% (62) have been committed to MSOP for over 26 years.
- Unlike most states with SOCC, **Minnesota does not regularly review detainee risk levels to assess the feasibility of safe reentry into the community.**

(Continued on page 4)

This increases the risk that detainees who could be moved to a less restrictive and less expensive setting remain in confinement longer than necessary, and thus longer than constitutionally permissible.

- **MSOP detainees wait an average of 625 days for a final decision to be made on their petitions for transfer to a less restrictive environment or discharge.** This also increases the risk that the most expensive and restrictive prevention resource will be utilized unnecessarily.
- Even after a court has ordered transfer to a less restrictive environment, in recent years **detainees have waited years for transfer.**
- Although courts make the final decisions about detainee petitions, **MSOP policies and recommendations by MSOP's clinical leadership significantly influence decisions about transfer and discharge.** Both the courts and MSOP thus bear responsibility for the unnecessarily low rates of transfer and discharge.
- Despite decades of critique by experts in the legal and treatment fields, **efforts to incrementally reform Minnesota's SOCC program have failed, leading to growing calls from diverse stakeholders to dismantle Minnesota's SOCC scheme and reallocate its multi-million-dollar budget to more effective prevention....** (Italics and bold in original)

The SOLPRC 2024 Report, at p. 2, explains:

"In early court cases, the state defended the constitutionality of its SOCC scheme by emphasizing the program's anticipated duration of less than three years for "model patients." [citing: *In re Linehan (Linehan III)*, 557 N.W.2d 171, 188 (Minn. 1996), cert. granted, judgment vacated sub nom., *Linehan v. Minnesota*, 522 U.S. 1011 (1997)]. Contrary to the state's representations in court, for most people commitment to MSOP constitutes an unofficial, but very real, life sentence. This "life sentence" takes place after someone has already served the time deemed appropriate by the criminal courts."

In reality, the brutal effect of all this is succinctly recounted in the SOLPRC 2024 Report, at p. 14, thus:

"Overall, for the vast majority of MSOP detainees, who have already served a lengthy criminal sentence, there is no clear path to community reentry and little hope of being granted a full discharge.

This reality is in stark contrast to the representations made by the state when the program was created. In the early 1990s, the state touted MSOP's new treatment program as a short-term intervention. MSOP was designed by Dr. Michael Farnsworth, the director of forensic psychiatry for the state of Minnesota [citing: *Eric S. Janus*, "Closing Pandora's Box: Sexual Predators and the Politics of Sexual Violence," 34 *Seton Hall L. Rev.* 1233, 1238 (2004)]. The program was

based on Farnsworth's research and designed to be a relatively short-term step-level program. [Id.] To defend the program's constitutionality, the state in 1995 made a formal representation to the Minnesota Supreme Court that an "average patient" was expected to complete the state's treatment program in a "minimum of 24 months" [citing *Call v. Gomez*, 535 N.W.2d 312, 319 n.5 (Minn. 1995) see also *In re Linehan (Linehan III)*, 557 N.W.2d 171, 188 (Minn. 1996), cert. granted, judgment vacated sub nom., *Linehan v. Minnesota*, 522 U.S. 1011 (1997)]. Treatment officials began backtracking as early as 2002, but only marginally: they then described the length of treatment as at least four years, noting that most patients are unable to complete the program in the minimum period. [Id. at 1238 n.21, citing an e-mail from Anita Schlink, Ph.D., then Clinical Dir. Of Minn. Sex Offender Program to Eric S. Janus (Aug. 19, 2002)]. As it turned out, not a single detainee was fully discharged from MSOP in the first twenty years of the program.

Today, most of the MSOP detainee population has been committed for well over a decade. As of September 19, 2023, 74% (557) of the approximately 747 people detained in MSOP had been there for over 10 years, 48% (364) had been in MSOP for over 15 years, 18% (138) had been detained for over two decades, and 8% (62) have been committed to MSOP for over 26 years." [citing] Information provided by MSOP's Records and Information Services Department to Ruby Brewer on October 2, 2023."

At page 15, the SOLPRC 2024 Report continues: Minnesota's SOCC scheme has been widely criticized for the glacial rate of release from confinement. Careful critiques, discussed further below, include reports from the Office of the Legislative Auditor in 2011, a Sex Offender Civil Commitment Advisory Task Force in 2012 and 2013, and a 2015 Federal District Court case, *Karsjens v. Jesson*, 109 F. Supp. 3d 1139 (D. Minn. 2015), 130....

...Minnesota's SOCC statute provides fewer procedural protections and extends civil commitment to a wider range of predicted conduct than other comparable state programs. As a result, Minnesota has become the highest per capita program in the nation ... with few discharges (see Figure 9) and the third-lowest rate of conditional release among states reporting data (see Figure 10)."

Regarding assertions of "dangerousness" or sexual re-offense if one committed to MSOP is released, the SOLPRC 2024 Report explains, at pp. 18-19:

"Judges typically determine "likelihood" based on the testimony of mental health professionals and the results of actuarial risk assessment tools. But the Minnesota courts have never subjected risk assessment testimony to the sort of reliability review that is normally applied to expert or scientific testimony [in footnote, explaining: See, e.g., *In re Schultz*, No. CX-99-1296, 1999 WL 1100941, at *5 (Minn. Ct.

FIGURE 9
SOCC Full Discharges by State as of 2023¹³³

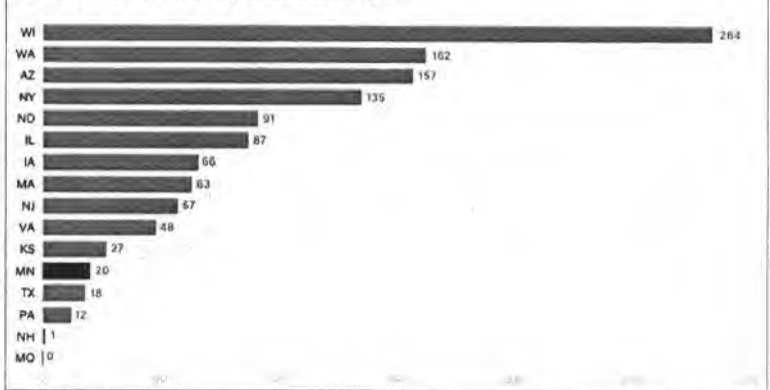
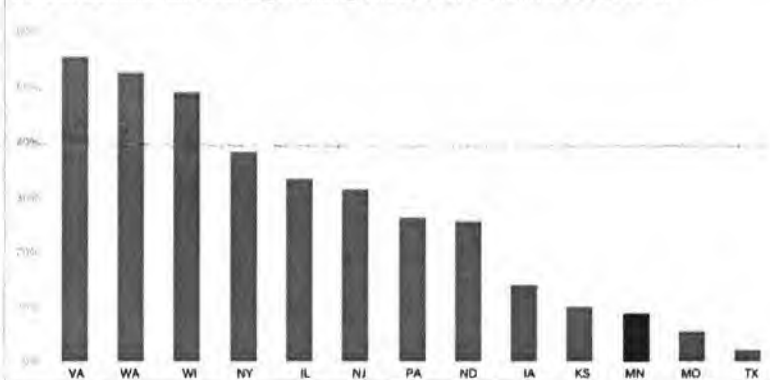


FIGURE 10
Rate of Conditional Discharge Among Those Ever Committed as of 2023.¹³⁴



App. Nov. 30, 1999); *In re Martinelli*, No. C6-98-569, 1998 WL 613845, at *6 (Minn. Ct. App. Sept. 15, 1998); *Matter of Clements*, 440 N.W.2d 133, 135-36 (Minn. Ct. App. 1989) (all characterizing questions about expert's testimony as determinative of "weight" and "credibility," not admissibility). And the courts have never insisted that risk assessment testimony be presented in quantified form with information about error rates and confidence intervals - critical information that would reveal the degree of certainty or uncertainty in the risk assessment methods used. Further, there is no dispute that some commitment decisions have been based on unreliable and outdated risk assessment tools. Although many of the empirical-actuarial risk assessment tools relied on to order commitments in the early 2000s have been updated to reflect more recent population data, Minnesota's SOCC system has no process to reconsider the commitment of individuals who were committed based on inflated and misleading risk. [For additional discussion of this issue, see Brief of Legal and Risk Assessment Experts Eric S. Janus and L. Maaike Helmus as Amici Curiae in support of Appellee, Rick v. Harpstead, Appellate Court File No. 23-2359 (8th Cir.).]

This means that likelihood determinations are largely subjective, relying on judicial and expert definitions of "highly likely" that vary from person to person. As a result, there is no structural assurance that persons who are committed are really the "most dangerous."

Indeed, the "highly likely" standard is so permissive that even some individuals with low to moderate risk assessment scores

and expert testimony supporting treatment in a less restrictive environment have been deemed "highly likely" to commit sexual harm and indefinitely committed."

The SOLPRC 2024 Report, at pp. 19-20, discusses the inadequacy of procedures for release from MSOP confinement and for end of MSOP commitment thus:

"Minnesota fails to properly release those who are committed. Both the structure of Minnesota's statute and MSOP's policies contribute to this problem. Most states provide for automatic and regular review of an individual's risk and need for continued confinement annually or biannually [Note 165: See SOCCPN, Civil Commitment of Sexual Offenders: Introduction and Overview (2015),

https://soccpn.org/wpcontent/uploads/2016/05/CC_Overview_SOCCPN_2.pdf (listing states that have enacted some form of SOCC statute, discussed further *infra* at note 131), but Minnesota does not. The state conducts no review until the detainee himself or herself petitions for a reduction in custody or discharge. And opportunities to file such petitions are limited. Detainees must wait six months after the disposition of their last petition (and, as mentioned above, petitions can take years to reach a decision). This not only differs from what is done in other states, but also differs from procedures for those civilly committed in Minnesota as mentally ill and dangerous.

The Executive Director of MSOP also has the right to file a petition on behalf of an individual, without any timing restrictions. Thus, if the Executive Director of MSOP believes that an individual should no longer be confined they can

immediately file a petition to have that person discharged. But this prerogative is rarely, if ever, exercised. On paper, this system sounds like it might provide appropriate review. **In practice, however, this petition process – and the review of suitability for confinement that depends on it – has been encumbered by major delays and has left even the most proactive detainees with infrequent review of their commitment.**

...Placing the burden of petitioning on detainees, no matter how simple the process, comes with the risk that some detainees who do not meet the criteria for continued confinement will not seek review. Whether the failure to petition comes from a sense of hopelessness, a lack of clear information about the process, or an inability to engage in the process, this policy risks leaving people who no longer meet the commitment standard confined in MSOP facilities for life. This risk is heightened for individuals with cognitive disabilities. [Note 169: According to MSOP administrators, 77 individuals residing at St. Peter currently participate in an alternative program of treatment for those with compromised cognitive function.]...

In addition, detainees currently do not receive acknowledgement or confirmation of receipt when they file a petition for transfer or discharge. Instead, the detainees hear nothing on the status of their petition until a hearing has been scheduled with the Special Review Board ("SRB"), a process that can take six months to a year after filing. At a minimum, detainees should be notified that their petition has been received and that a hearing will be scheduled in due course. A lack of communication leaves detainees in limbo without certainty that they are truly in the queue for their case to be heard and leaves them without the basic information needed to be effective self-advocates.

Although this risk of unnecessary and unlawful confinement could be mitigated by the Executive Director's statutory right to petition on detainees' behalf, we are not aware of MSOP's Executive Director requesting transfer or discharge with any regularity. Unnecessarily long confinement is, of course, a violation of law, the Constitution, and basic human rights. It is also a wholly avoidable waste of state prevention resources. Fixing this problem does not require statutory change and should be a top priority."

In getting to the crux of MSOP's internal processes that effectively block or confuse the path to release and end of commitment, the **SOLPRC 2024 Report**, at pp. 20-24, sets forth the following:

"Bottlenecks in the Step-Down Process

Even where individuals learn of and exercise their statutory rights to petition for transfer or discharge, massive delays prevent timely review and unnecessarily extend the confinement of MSOP's population.

The step-down and discharge process consists of two steps: (1) review by the Special Review Board ("SRB"), and (2) review by the Commitment Appeal Panel

("CAP"). Critically, no reduction in custody recommendation by the SRB is effective until it has been reviewed by CAP, and a CAP order has been issued. As a result, and as discussed further below, this two-step process has been criticized for redundancies and delays which leave detainees in confinement longer than can be justified.

First, after a petition is filed the SRB holds a hearing and issues a recommendation and report. The SRB is made up of three members and must include one attorney, one psychiatrist or psychologist, and one other mental health professional [Note 172: Minnesota Legislative Reference Library, Information on Minnesota State Agencies, Boards, Task Forces, and Commissions: Special Review Board (May 24, 2021), <https://www.lrl.mn.gov/agencies/detail?AgencyID=1041>]. After filing a petition, the detainee is entitled to a court-appointed attorney to represent them throughout the petition process.

Before the SRB makes its recommendation, MSOP's clinical leadership files a "Treatment Report" that sets forth its position on the petition, and forensic evaluators employed by the DHS file a "Sexual Violence Risk Assessment." At the SRB hearing, counsel for the petitioner typically offers information supporting the petition.

Petitions are reviewed in light of statutory criteria that vary depending on the requested relief.

In assessing a petition for transfer to Community Preparation Services (CPS), five statutory factors must be considered:

(1) "the person's clinical progress and present treatment needs;" (2) "the need for security to accomplish continuing treatment;" (3) "the need for continued institutionalization;" (4) "which facility can best meet the person's needs;" and (5) "whether transfer can be accomplished with a reasonable degree of safety for the public."

When the petition requests a provisional discharge, the SRB and CAP must consider: "(1) whether the committed person's course of treatment and present mental status indicate there is no longer a need for treatment and supervision in the committed person's current treatment setting" – this in practice has been whether treatment professionals employed by MSOP believe that the petitioner has completed the MSOP treatment program [Note 176: See *Karsjens v. Jesson*, 109 F. Supp. 3d 1139, 1165 (D. Minn. 2015), rev'd and remanded sub nom., *Karsjens v. Piper (Karsjens I)*, 845 F.3d 394 (8th Cir. 2017) ("The MSOP will only support a petition for a reduction in custody if the petitioning individual fully completes the treatment program. Commissioner Jesson credibly testified that the MSOP will only support individuals for discharge if they had been successful in finishing treatment and defined 'successful' to mean 'finished.' Johnston credibly testified that the MSOP's practice is that committed individuals must be in Phase III for the MSOP to support their petition."); and "(2) whether the conditions of the provisional discharge

plan will provide a reasonable degree of protection to the public and will enable the committed person to adjust successfully to the community."]

For a full discharge, the SRB and CAP assess whether the "committed person is capable of making an acceptable adjustment to open society, is no longer dangerous to the public, and is no longer in need of treatment and supervision." [Id.] And "whether specific conditions exist to provide a reasonable degree of protection to the public and to assist the committed person in adjusting to the community." [Id.]

Once the SRB issues a report and recommendation, the parties can appeal by filing a petition for rehearing and reconsideration with CAP. Most SRB determinations are appealed. CAP gives all petitions that come before it de novo review, meaning that it gives no deference to the SRB's findings or conclusions. Once a petition comes before CAP,

CAP may appoint an independent examiner to offer an opinion as to risk level.

As noted above, "[n]o reduction in custody or reversal of a revocation of provisional discharge recommended by the special review board is effective until it has been reviewed by the [CAP] ..." This means that two layers of review must occur for a petition to be granted. Further, the SRB process does not serve the function of building a record for review by CAP. Instead, CAP reviews the cases afresh, without relying on the SRB's findings. As a result, the SRB's time consuming review process is entirely superfluous.

A review of available public data from 2018 through 2021 shows that a petition for transfer, provisional discharge, or discharge remains pending for an average of 625 days before CAP issues a final order [Note 182: See Brief of Legal and Treatment Experts Michael H. Miner and Eric S. Janus as Amici Curiae in Support of Appellants at 13 n.30, *McDeid v. Johnston*, Nos. A21-0042, A21-0043, (Minn. Dec. 22, 2021) (compiling data from the Minnesota Appellate Courts Case Management System, at <https://macsnc.courts.state.mn.us/ctrack/search/publicCaseSearch.do>.)] Thus, **simply following the procedure to get from a petition to an order on that petition takes almost two years.**

Several problems with the petition process combine to produce these delays. First, the statute's rigid multi-layer reduction-in-custody procedure unnecessarily slows the review process. To address constitutionally dubious delays in discharge and step-down, legislators should consider options to streamline this process, including eliminating the superfluous SRB process from Minnesota's SOCC statutory scheme.

Independent examiners provide critical information, but recently too few engaged in the CAP review process to meet demand [Note 183: Although there were over 20 Independent Examiners working with CAP in January of 2018, by March of 2023 there were only 4 Independent Ex-

aminers working with CAP. Presentation by Judge Jay Quam, Commitment Appeal Panel (CAP) Update, DHS CLE (September 20, 2023)]. As of January 2023, 141 petitions were awaiting review by an independent examiner [Id.]. This is at least partially due to the low rates of compensation that DHS has historically offered to independent examiners [Note 185: In the spring of 2023, DHS raised rates in response to requests from the judiciary. Over the last few months, this increase in pay has resulted in a significant increase in the number of available independent examiners. See id.] **Backlogs in the process could be significantly reduced by consistently providing at or above market-level compensation to independent examiners.**

To this end, compensation for independent examiners should not be set by DHS, an entity that is also a party to CAP proceedings. Most often, DHS opposes discharge or transfer, and therefore **may have little incentive to address backlogs in the CAP process.** To ensure that DHS is not able to unilaterally stall the transfer and discharge process, independent examiner compensation should be set by the judiciary and sufficient funds allocated to ensure that the shortage of examiners does not continue to cause delays.

MSOP Failures to Transfer Detainees Result in Due Process Violations.

Even when a petition is granted, recent lawsuits have highlighted major delays in the implementation of CAP orders directing transfer to the less restrictive Community Preparation Services ("CPS") facility.

In December 2021, the CAP held the DHS Commissioner in contempt for failing to transfer an MSOP detainee to CPS after CAP had granted his petition for transfer [Note 186: *In the Matter of the Civil Commitment of Al Stone Folsom*, No. AP19-9153, at 8 (Commitment Appeal Panel Dec. 2, 2021) (Contempt Order)]. In CAP's findings of contempt, **the Court noted that "55+ MSOP detainees have had their progression similarly delayed by a failure to transfer for two years or more [Id.]**

Even more recently, in February 2023, the Minnesota Supreme Court ruled on the right to timely transfer in *McDeid v. Johnston*. In *McDeid*, two civilly committed individuals filed a lawsuit after waiting over two years to receive the transfer to CPS that CAP had ordered [*McDeid v. Johnston*, 984 N.W.2d 864, 870 (Minn. 2023)]. The State argued that a CAP transfer order is not binding on the state [Id. at 875]. On February 1, 2023, the Minnesota Supreme Court squarely rejected the State's argument [Id. at 874], holding that detainees have a clearly established due process right to CPS transfer within a reasonable time following a CAP transfer order [Id. at 878-79]. This case was remanded to the Court of Appeals on a separate legal question and it remains to be seen how this holding will impact delays in the transfer process.

(Continued on page 6)

These delays have serious implications for MSOP's legitimacy and effectiveness. Timely advancement in the program is not only a minimal constitutional requirement, but it is essential for maintaining even the appearance of legitimacy. Understandably, unjustified delays in advancement lead individual detainees to become frustrated and angry, sometimes leading to regression in their behavior. This regression is then viewed by staff as an indication that they are not ready for the already approved advancement. Further, detainees who see their peers' advancement blocked, even after approval, may conclude that there is little hope of advancement and of being discharged. This has produced an overall culture of hopelessness and frustration.

In recent years, MSOP administrators have cited a lack of beds to accommodate the detainees with orders for transfer to CPS. They have further noted repeated, unsuccessful requests to the legislature for funding to expand CPS facilities. In fact, in the State's filing in *McDeid*, DHS asserted that it requested funds to expand CPS in 2016, 2017, 2018, and 2019, but that the legislature did not provide that funding [Note 192: Respondents' Brief, *McDeid v. Johnston*, Minn. A21-0042, A21-0043 (2022)]. More recently, MSOP administrators report that the delay in transfer to CPS is not due to a lack of beds, but rather the need to hire additional clinical staff, and that the 2023 legislative session approved construction of an additional 30 CPS beds [Note 193: E-mail from Nancy Johnston, Exec. Dir., Minn. Sex Offender Program to Eric Janus, Dir., SOLPRC (Jan. 12, 2024, 10:18 CDT) (on file with SOLPRC)].

Detainees, judges, attorneys, and the MSOP administration have all acknowledged that these delays, no matter the cause, are unacceptable. They imperil not only the program's constitutional legitimacy, but the appropriate allocation of scarce prevention resources. Each unnecessary day in the MSOP program represents a violation of constitutional rights and a substantial expenditure of money that does not advance the prevention agenda that all agree is of central importance. This is a clear problem with a clear solution. It should be fixed promptly.

Both MSOP and the courts are responsible for the low rate of moving low-risk detainees to less restrictive and less expensive settings.

MSOP leadership generally disclaims responsibility for the excessive duration of confinement at MSOP, emphasizing that the commitment process is "courts in, courts out." Of course, a court must order commitment to and release from MSOP, and in this sense the claim is legalistically correct. But MSOP's disclaimer ignores the significant influence that the program has over the discharge process.

Begin with the facts. MSOP recommendations on stepdown petitions are almost always outcome determinative. MSOP's own data show that clinical leadership

supported only 15% of petitions for discharge or transfer during the seven-year period from 2015 to 2021 [Note 194: Data on Petitions Filed Annually from 2012 – 2022, Data Request Response from MSOP to SOLPRC (June 10, 2022) (on file with SOLPRC) (showing that a total of 966 petitions were reflected in the data from 2015 to 2021. Out of 966 petitions, MSOP supported only 142 (15%)). In that same period, CAP, which makes final discharge and transfer decisions, granted approximately 91% of those petitions supported by clinical leadership [Note 195: Out of the 142 petitions that MSOP supported, CAP granted 129 (91%). *Id.*] Conversely, CAP granted discharge or transfer petitions which were not supported by MSOP only 9% of the time Note 196: Out of 966 petitions, MSOP did not support 824. Out of those 824 petitions that MSOP did not support, CAP granted 78 (9%).] **In other words, the position of MSOP is tremendously influential in the petition process.**

That influence is shaped by two key interrelated practices adopted by MSOP, both of which improperly raise the bar for granting step-down petitions, though neither is mandated by law. The first is MSOP's longstanding practice of supporting petitions for step-down based primarily on treatment progression. While treatment progression is not irrelevant to risk-assessment, it should not be the dispositive factor. Some detainees are low risk even though they have not progressed in treatment. Other states recognize this important nuance and base their step-down decisions on a holistic assessment of risk [Note 197: Civil Commitment of Sex Offenders, Off. of the Legis. Auditor, 23–24 (Mar. 2011), <https://www.auditor.leg.state.mn.us/ped/pedrep/ccso.pdf>].

The second practice compounds the problem. As discussed above, MSOP's practice is to place the burden on detainees to initiate the step-down process. But MSOP's Executive Director has statutory authority to initiate the process herself. **To our knowledge, this has not been done, despite recommendations from outside entities that have reviewed MSOP, such as the Expert Panel appointed by Federal District Judge Donovan Frank in *Karsjens et al. v. Jesson et al.* in 2015** [Note 198: Expert Report and Recommendations at 60, *Karsjens v. Jesson*, 109 F. Supp. 3d 1139, No. 0:11-cv-03659-DWF-JJK (D. Minn. 2015), ECF No. 658, <http://stmdia.startribune.com/documents/Expert+panel+report+on+sex+offender+program.pdf>].

The burden of this administrative practice falls most heavily on detainees who have compromised cognitive function, serious disabilities, or who are elderly. Progress in MSOP's treatment program may be impaired for these populations because of their compromised functioning. But these same limitations likely also reduce their risk, and they may meet the criteria for safe re-entry despite their failure to complete the treatment program. Their compromised functioning may also impair their

ability to follow the administrative guidelines to file a step-down petition.

At a minimum, MSOP's Executive Director should actively identify detainees whose risk is low, even if they have not progressed in treatment. And the Executive Director should promptly submit step-down petitions on their behalf to facilitate safe re-entry. Although courts make the final decision, **MSOP's administration should acknowledge its influential role and exercise its statutory power to identify and support discharge petitions for those low-risk individuals likely to meet Minnesota's SOCC step-down standards.** [Note 199: Minnesota's SOCC discharge standard can be found at Minn. Stat. § 253D.31.

Minnesota's Failure to Provide Appropriate Treatment and Conditions of Confinement

MSOP's Treatment Program

MSOP is required to provide "treatment, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary." Generally accepted practices of inpatient treatment for those who have committed sex offenses have been published by two organizations: the Association for the Treatment of Sexual Abusers ("ATSA") [Note 201: ATSA is an international, multi-disciplinary organization dedicated to preventing sexual abuse by providing treatment to individuals who sexually offend, promoting research that leads to the effective treatment and management of individuals who have sexually offended, and encouraging empirically based public policy and prevention efforts. The 2,800 professional members of ATSA include leading researchers who study sexual abuse and effective treatment interventions, experts in the assessment, treatment, and management of individuals who sexually offend, and victims' advocates.] and the Sex Offender Civil Commitment Programs Network ("SOCCPN") [Note 202: "SOCCPN gathers information from sex offender civil commitment programs in 19 different states . . . and determines generally accepted practices . . . based on the information gathered." See *Howe v. Godinez*, No. 14-CV-844-SMY, 2021 WL 4050852, at *8 (S.D. Ill. Sept. 6, 2021)]. According to ATSA and SOCCPN, treatment programs in inpatient civil commitment settings should be grounded in Risk-Need-Responsivity ("RNR") principles [Note 203: See ATSA, Civil Commitment: One Approach for Management of Individuals Who Have Sexually Abused 6 (2020), <https://www.atsa.com/policy/CivilCommitmentApproach%20forManagement.pdf>; R. Karl Hanson et al., The Principles of Effective Correctional Treatment Also Apply to Sexual Offenders: A Meta-Analysis, 36 *Crim. Just. & Behav.* 865, 867 (2009)]. Research shows that treatment programs that follow RNR principles of offender rehabilitation are associated with lower rates of sexual recidivism when compared to programs that do not [Note 204: See ATSA & SOCCPN, *infra* note 206; ATSA, *supra* note 203, at 1, 5–7]. ATSA summa-

rizes the RNR principles as follows:

[T]he Risk principle indicates that the intensity of services should be determined by the risk level of the individual, with higher risk individuals receiving more intensive services than lower risk individuals.

The Need principle maintains that interventions should target criminogenic needs (i.e., the factors that predispose an individual to sexual offending) associated with recidivism risk.

The Responsivity principle states that interventions should be provided in a manner that incorporates the individual's unique characteristics such as learning style, level of motivation, and other individual factors that may impact delivery of services, to maximize their treatment response Note 206: ATSA, *supra* note 203, at 5–6].

In conjunction with RNR principles, ATSA's practice guidelines state that treatment programs must foster engagement and internal motivation, clearly delineate the criteria for successful completion, and regularly communicate and assess progress. ATSA and SOCCPN have jointly recognized that "once risk and need are reduced to a level that is manageable within a community-based setting," "there should be a mechanism to swiftly transition individuals to less restrictive alternatives and full discharge, without preventable delays." [Note 206: ATSA, Civil Commitment: Best Practice Informed Recommendations 3 (Feb. 2021), <https://www.atsa.com/policy/CivilCommitmentSummary.pdf>. ATSA's Best Practice Informed Recommendations "are made through a collaboration between [ATSA] and [SOCCPN]." *Id.*].

As we set out below, clear and consistent evidence shows that the MSOP treatment regime violates the statutory command that it provide treatment meeting these "contemporary professional standards."

MSOP currently employs a three-phase treatment program. MSOP describes its phased approach, stating:

Clients initially address treatment-interfering behaviors and attitudes (Phase I) in preparation for focusing on their patterns of abuse and identifying and resolving the underlying issues in their offenses (Phase II). Clients in the later stages of treatment focus on deinstitutionalization and reintegration, applying the skills they acquired in treatment across settings and maintaining the changes they have made while managing their risk for re-offense (Phase III).

Detainees do not have clarity on the criteria for successful completion of each phase and they are often stuck in Phase I or II for decades. This confusion has been exacerbated by the significant delays in the petition process and transfer to CPS.

MSOP has been repeatedly criticized for failing to establish clear expectations to advance through the treatment program. In the 2015 Federal District Court case, *Karsjens v. Jesson*, the Court noted that "[t]he lack of clear guidelines for treatment

(Continued on page 7)

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" and that committed individuals "consistently expressed concerns that slow movement through the program ...was demoralizing, increased hopelessness, and negatively impacted motivation and engagement." [Note 207: *Karsjens v. Jesson*, 109 F. Supp. 3d 1139, 1156-57 (D. Minn. 2015), rev'd and remanded sub nom., *Karsjens v. Piper (Karsjens I)*, 845 F.3d 394 (8th Cir. 2017); see also Civil Commitment of Sex Offenders, *supra* note 197, at 71 (finding that "[a] lack of client motivation has been a barrier to progression in treatment" at the MSOP).

Recent conversations with detainees reveal that progression often feels unpredictable and can depend on external conditions like staffing turnover. Due to poor staff retention at MSOP, detainees often find that their treatment progress is interrupted when they are placed with a new provider. As one detainee, Joshua Brooks, stated: "It doesn't matter how much treatment you do, it starts over. There's therapists changing out. I, myself, have had 22 different therapists in 11 years." [Note 208: E-mail from Tiffany Minkel, Member of OCEAN, to M. Ranum (Oct. 13, 2022, 10:06 CDT) (on file with SOLPRC)].

Detainees further report that treatment progression can be interrupted by disciplinary infractions. Within MSOP, disciplinary infractions are documented using "BERs" or Behavioral Expectation Reports. Detainees report that BERs are issued for "bad" behavior which can include any policy violation, including speaking negatively about MSOP's program. It can also include conduct that is a symptom of a mental health disorder. BERs can result in extended periods of isolation when a detainee is punished by being confined to their room, sometimes for weeks. During these periods of administrative segregation, detainees are reportedly unable to attend treatment sessions and, as a result, treatment progress is stalled. Additionally, as reported in the 706 Expert Report, treatment progress is often delayed or reversed because of BERs for behaviors that have no relationship to sexual offending risk or are for relatively minor infractions [Note 209: See Expert Report and Recommendations at 69, *Karsjens v. Jesson*, 109 F. Supp. 3d 1139, No. 0:11-cv-03659-DWF-JJK (D. Minn. 2015), ECF No. 658, <http://stmedia.startribune.com/documents/Expert+panel-report+on+sex+offender+program.pdf>].

The State's failure to provide clarity on the criteria and timeline for treatment progression undermines client expectations that they will ever be released from confinement, no matter how carefully and earnestly they adhere to MSOP's treatment program. The failure to provide clarity also violates the state's statutory obligation to provide the treatment "best adapted, according to contemporary professional standards, to

rendering further supervision unnecessary." These are cascading failures that lead to decreased engagement, trust, and motivation across the MSOP population, thus reducing the efficacy of MSOP treatment and preventing the program from achieving its stated treatment and public safety goals. Correcting these deficiencies is completely within the prerogative of MSOP and requires no legislative change."

Thus, the question must be faced whether patting the slow-kid's head is truly helpful toward accelerating learning, or instead whether it just produces incorrect self-satisfaction and complacency that block improvement? After all, until the slow-kid finds out how far off the mark he is, improvement is impossible. And the same applies to MSOP.

As is the case in MSOP, "In enforced treatment, patients come to view their therapists as their jailers, agents of the state, and punitive authority figures. Involuntary patients learn to minimize symptoms, ingratiate their therapists, and seek forgiveness. The reciprocal, mutual, trusting relationship in voluntary mental health treatment is often reduced to a game of manipulations by the patient and staff in involuntary treatment." *Robert Weltstein, "A Psychiatric Perspective on Washington's Sexually Violent Predators Statute," 15 Puget Sound L. Rev. 597, 618 (1992).*

Specifics of this illusory façade of purported treatment-toward-release, include:

- In the first place, a study by *Gregory DeClue & Denis L. Zavodny*, "This Just In: Sex Offender Treatment Is Beneficial for One in 28 Patients," 17(4) *Sex Offender Law Report* 49-64 (June/July 2016), found that CBT treatment results in significant recidivism reduction for only 1 out of 28 treatment participants. Since the chief goal of MSOP's CBT-based treatment is the reduction of recidivism, this fundamental fact points up MSOP's inability to achieve this centerpiece goal. The point of the De-Clue and Zavodny study is not that sex offenders have high recidivism tendency. On the contrary, the point is that so very few go on to commit further sexual crimes even if they have no treatment. The facts that one out of 28 might gain a reduced tendency toward recidivism through treatment, but that no process of assessment can ascertain whether any sample of sex offenders – regardless of past sex-crime records – contains that 1 out of 28 (*Richard Wollert*, "Low Base Rates Limit Expert Certainty When Current Actuarials Are Used to Identify Sexually Violent Predators," 12 *Psychology, Public Policy and Law*, 56 [February 2006]; *Robert A. Prentky, Ph.D. & Richard W. Wollert, Ph.D.*, "Using Actuarial Risk Assessment Instruments to Estimate Absolute Risk", Ch. 6 in *Robert A. Prentky, Howard E. Barbaree, & Eric S. Janus, eds., Sexual Predators: Society, Risk, and the Law* [New York: Routledge, 2015]), means that there is no need or point to confining hundreds of former sex offenders on

the assertion that they all "need" sex offender treatment, without which they would supposedly again commit one or more sex crimes after release. There is simply no way to know that, and this study shows that the odds are extremely against that claim.

Despite higher legislative appropriation for MSOP now than ten years ago, there now are only half the hours of group therapy in a treatment week (2.0) than at that same point in the past (4.0); further, at least one "psychoeducational module" was assigned to each treatment participant, then per quarter (1.5m hours in session per week), there are no such modules now offered at all; overall result: then: 5.5 hours of treatment per week, now: 2.0 hours per week of treatment;

- Advancements from Phase 2 to Phase 3 of treatment are now so uncommon that there currently are over 500 treatment participants in Phase 2, but only approximately 35 in Phase 3;
- The inherent impossibility of extinguishing deviant attractions, admitted by MSOP's own clinicians;
- "Need areas" rhetoric and subjective attribution of "dynamic risk factors" which, contrary to the term "dynamic" continue to be applied to the treatment participant year upon year regardless of what the participant has done in terms of treatment assignments or how many times he has repetitively been assigned the same assignments, without any scored feedback that would indicate any failure to learn or apply the precepts of the assignment or any written critique of what, specifically, in the assignment was not learned correctly or completely, and how such error or incompleteness can be corrected, all of which, taken together appears to present a fair inference that such use of need areas and dynamic risk factors are not actually being used as teaching or specific assessment tools, but rather merely as providing excuses to keep a given treatment participant confined;
- Failure to give any specific definition or application of what constitutes and/or is needed to demonstrate "meaningful change" as to any Matrix element, and refusal to acknowledge any "meaningful change" as to any specific aspect of treatment; or as to treatment success overall, whether as to any phase completion or even despite successful treatment completion; in nearly every case, the phrase is merely used as a negative conclusory statement (e.g., "lack of meaningful change") without scoring or narrative judgment specific as to any sub-element needed to establish "meaningful change."
- Lack of releases through treatment (i.e., MSOP "support" of a petition by a treatment participant for release: 1 known by this writer out of more than 850 confinees, from MSOP inception in 1995 to date [30 years], including deceased detainees);
- Presumptive duration of confinement through old-age to death (i.e., more

confinees have died in MSOP confinement than have been granted provisional discharge; and

- Insistence on an unattainable 'zero-percent recidivism risk' "public safety guarantee" before granting release. (As to pedosexuals ("pedophiles"), MSOP can excuse its refusal to release same, even after a decade or more of its treatment, that the confinee continues to have pedophilic attractions, and therefore presents some level of risk of re-offense – and hence does not possess a "guarantee" of public safety. Therefore, MSOP is simply a thinly disguised, artificially 'treatment justified' permanent (natural-life) preventive detention scheme.

All of these aspects present an undeniable overall revelation of a commitment scheme intent on natural-life preventive detention, with only the sheerest gossamer veil of claimed treatment, in reality not in earnest or even merely good faith. Unquestionably, that sole realistic goal of preventive detention shows the undeniably punitive aim and function of SPP/SDP commitment.

An MSOP censor has complained that these aer not facts, bit instead just matters of opinion. However, I submit that the facts in all of the foregoing either state these things outright, cite to academic works or other publications that do so, or are fair inferences from such other matters of fact. You can decide for yourself. Regardless, all of the foregoing, taken together, establish clearly that MSOP is a failure at treating and releasing even just a substantial portion of its confinees, and doing sufficiently swiftly, rather than allowing more to die from old-age-related causes in confinement.

Not to be ignored is MSOP's obsession with polygraph testing of confinees as to their past sexual misconduct. *Warren Maas*, in "Erosion of Constitutional Rights in Commitment of Sex Offenders," 29 *William Mitchell Law Review* 1241, 1259, reports: "The patient must take responsibility for each alleged incident or they will not be able to complete the program." MSOP officials insist that each treatment participant undergo polygraph examination – repeatedly, until the final polygraph exam indicates that no additional unreported offenses remain undisclosed by the participant.

Refusal to take these polygraph exams or to undergo these interrogation sessions is deemed to be refusal of treatment, for which the refusing detainee will be reported to correctional supervision agent, who in turn will move to return him to prison for this insistence on standing on his right against self-incrimination and his First Amendment right not to speak upon demand.

Effectively, this is used to gain admissions from the confinee of unconvicted (even never disclosed) sexual acts predating his 'index offense' arrest. First, given the repeal of statutes of limitation as to sexual crimes, any attorney would advise any MSOP confinee of the extreme legal peril the confinee would place himself in by taking such an exam or admitting any such

(Continued on page 8)

past unconvicted acts, especially recalling that MSOP assessment staff and therapists are all legally "mandated reporters" who must convey each such admission to the appropriate law enforcement authorities. Of sex offenders, explained, in Report to Schiff Hardin & Waite and the American Civil Liberties Union in Hargett, et al v. Minnesota, explaining that either such a waiver of confidentiality, or such a full disclosure, improves the likelihood of success in treatment.

In treating drug addiction, it can be important to know what type of drugs the patient has been using, and how frequently he has been doing so. However, it is not ordinarily necessary to know all of the details surrounding each of his prior drug use.

It is clear that a man is sexually attracted to children, what is important from the treatment perspective is not necessarily to know all of the details of each and every one of his prior offenses, but more importantly to know that he now has the resolve, the capability and the support necessary so that he will not offend again.

...In my professional opinion, the program's practices and policies regarding confidentiality of patient information (particularly with respect to compelling the disclosure of prior criminal acts) represents a substantial departure from accepted practice, judgment, and/or standards in the field of inpatient mental health care."

...The 'treatment plan' for any MSOP detainee-specific, concrete goals and objectives that can be objectively graded. If these treatment plans could be satisfactorily achieved, doing so consistently would inexorably lead to program completion. However, for as long as the treatment participant still has amorphous, vague, subjectively assigned tasks listed as unfilled in his treatment plan, he has not completed treatment, and thus yet another year's plan, complete with yet more of such amorphous, vague, subjectively assigned tasks, will be prepared. Such claimed 'dynamic risk factors' (as 'criminogenic needs'), are endless and deliberately vague to avoid accountability. In short, a participant can never finish these unascertainable, Herculean tasks.

Too many more points about MSOP's absolute failure exist to cite here. Suffice it to say that, by its almost total non-release, MSOP itself implicitly acknowledges that its treatment is such a failure as to leave all confinees too dangerous to release, in its view. This is failure by definition.

Given all that has just been observed

about MSOP, of what use, if any, is a PEN award that, effectively, even if based on true facts, would only serve as a tepid pat on the head for the slow kid in class, who, even though failing...is complimented for taking the award. Hence, the relationship of whatever the Baldrige award is deemed by its judges to reflect in terms of "world-class performance" may be seeking to accomplish. One Baldrige examiner famously noted "the problem of the Baldrige-winning buggy-whip manufacturer": the output whips may have been top-class, but that does not avoid the fact that buggy whips are not in any significant use these days.

One observation made by Prof. Garvin was that gaining a Baldrige Award is not a reward, on the heels of installing its current treatment modality (ca. 2011), MSOP changed to a new mission statement mentioning provision of "world-class treatment." Now, the only output change is a nominal increase from zero to very few clients per year released via the CAP process.

Just for one important element used by Baldrige in evaluating health systems, the "Customer Engagement" aspect poses the question: How do you build relationships and enhance the patient and other customer experience? In this, focus is placed on these sub-questions: How do you:

- Build a more patient-focused organization and enhance your brand, and
- Meet patients' requirements and exceed their expectations in each stage of their relationship with you?

importance of patient expectations and preferences in this regard "because patient requirements and preferences are particularly critical for the design and delivery of key work processes (patient care), often on a patient-by-patient basis."

Another sub-point here asks this question: How do you manage patient complaints?

Yet another sub-point begins with this question: How do your patient-experience processes promote and ensure fair treatment for different patients, patient groups, ...and market segments?

Finally, the Customer Engagement element concludes with this overall question: How do you determine patient and other-customer satisfaction, dissatisfaction, and engagement? More to the point, one of the sub-questions in this is: How do you take action on the results of satisfaction, dissatisfaction, and engagement determination methods? And last, this question: How do you obtain information on patients and other customer satisfaction with your organization relative to competitors and other organizations providing similar services?

In the case of MSOP, there is clearly no effort by management to make MSOP more "patient focused", except to come up with ways to make life more difficult and less challenging for therapists job candidates, when they learn that the entity with opening performance at completing treatment and recommending release, actual performance at getting this done was nil for nearly the first 20 years and now is merely minimal, not substantial.

As to Question 3, MSOP makes no effort to "Meet patients' requirements," much less to "exceed their expectations" at any point. Further, MSOP has no method in place of invariably results in lack of any corrective action by administration. In sum, even this one point of "Customer Engagement" should have caused MSOP to fail to be granted a Baldrige Award. The fact that it did not do so appears to suggest that facts were withheld or falsified as presented to the PEN Baldrige examiner.

Among other major categories are: Leadership, Strategic Planning, Knowledge Management, and Organizational Performance Results. MSOP fails each of these categories as well. As noted above, the results in terms of gaining releases for patients, MSOP has remained between absolute nil and only infinitesimal percentage and act as if the infinitesimal percentage of releases is sufficient - even a claimed sign of success. And DCT leadership apparently tacitly tolerates this. It then

Further, although the field of sex offender treatment has been radically advancing in the last ten years, there has been no effort to amass, organize, and apply any of this new knowledge, which, properly understood, would allow radical change to the treatment in MSOP, providing radically increased release rates. Ignorance is simply the lack of possession of knowledge, through no fault of the one without the knowledge. Being an ignoramus, however, is defined as one abysmally devoid from even basic knowledge through a resistance to learning, a refusal to accept knowledge. By this definition, MSOP is an organizational ignoramus.

Merely calling a new process "world-class" does not make it so. At the current rate of releases, it would take about 30 years to release all current MSOP confinees (not counting those who could be committed in the future). Of course, given the age distribution, half of this drainage of confinees would be those who waited as long as they could for release and then simply died while

still confined. This is far from "world-class" anything. MSOP's mistake (if it was unintentional) was assuming that it had the true basis of an optimal sex offender treatment program. The mistake was just making that erroneous system more exactly wrong.

MSOP cannot remotely be said to qualify for the Baldrige award investigation. Only one of two conclusions can thus be reached: Either PEN learned these facts and chose to proceed with grant of the award regardless, or MSOP or DCT fed PEN examiners falsehoods contrary to actual facts and thereby wrongly procured the PEN Baldrige award. Given the timing of the announcement of this award (in the midst of the annual Minnesota Legislative Session)

Those not involved in the evaluation - in this case MSOP's patients (obviously interested parties) - have no way of knowing what was told to the Baldrige evaluation entity (in this case PEN) to gain the award. So we can only provide correct facts (as above) that we think should have blocked that award. However, this has no effect if PEN was complicit in making an unjustified award. This writer only recently became aware of the Baldrige Award granted to MSOP in three of the last four years (2021 through 2024). Nonetheless, this set of years has involved the same persistent problems of MSOP process and administration that should have barred that award in falsified facts for the purpose of expeditiously granting unjustified awards in each of these years. Clearly then, integrity of the Baldrige process has been compromised.

...the Baldrige Award, the inconsistency of MSOP's abysmal performance with the standards for the award, coupled with grant of the award, show at least that facts communicated must have been misleading, if not factually false. This makes such communications to PEN a violation of the additional NIST ethic forbidding false or misleading information to Baldrige examiners. Acceptance by PEN of these falsehoods/misleading statements reduces the Baldrige award process to a complicit self-serving 'whitewash' of undeserving recipients such as MSOP. The "Consensus Review" among all examiners involved in the award to MSOP strongly suggests that the choice to ignore glaringly apparent problems with MSOP was a collegial decision, offering a firm inference of a choice to grant the award regardless of the facts. This is a blatant corruption of the Baldrige process.

Another ethic imposed by NIST is avoidance of conflicts of interest. Yet in this
(Continued on page 9)

case, how can this protect the award process integrity when PEN has a board member (Marshall Smith, also chief executive officer of Direct Care and Treatment [DCT], which is the administrative "parent" agency over MSOP) who nominates MSOP and other sub-entities within DCT to receive the Baldrige Award? Surely this transgresses the conflict of interest prohibition.

Editor's Note: The op-ed above draws on information available to the author at press time. Input will be welcomed from readers having information not mentioned here.

PEN Award Follow-Up:

MSOP 2022, 2023 Reports Confirm Its Non-Performance & Failure. MSOP's Only Award Should Be for Exceptional

The banner article above discussed an award conferred by "PEN," a non-governmental entity (NGO), on MSOP as to 2021, 2022, and 2024, purportedly for "performance excellence." However, as observed in that article, in those and in all other years, MSOP's lack of significant performance as to all relevant metrics has been, and now remains the stuff of a cautionary parable in Agency Administration 101. Since that article was written, Annual Reports by MSOP failed for another year and throughput performance whatsoever. Here-with are some of these supplemental, damning facts:

According to the Minnesota Sex Offender Program (MSOP) Annual Report 2022,

- Between 2021 and 2022, MSOP staff vacancies increased over 13%.
- Out of a confined population of roughly 750, CAP orders for grant of provisional discharge only increased from 14 in 2021 to 18 in 2022 – reflecting an annual rate of only one out of about every 42 confinees. At this rate, it would take 42 committed going forward in that same future period). Confirming this turtle-like progress, by the end of 2022, only 44 transfer orders had been granted final discharge from MSOP commitment. There were only 3 full discharges from MSOP commitment in 2022. This minimal rate has remained more or less steady from 2018 through 2023 – reporting nothing to warrant the senior- and near-senior-age range of a large number of current confinees, it is

probable that more current confinees will die in MSOP confinement in the near future from old-age-related causes than will achieve even merely provisional discharge. MSOP leadership has never evinced any concern over this plight and the failure of MSOP it reflects, and has never taken any effective corrective action to speed treatment delivery and support to assist in outplacement to provisional discharge. MSOP appears to wallow in the glaringly false urban legend that former sexual offenders from decades ago remain highly likely to reoffend – even deep into old age.

- MSOP was under supervision by both the Minnesota Department of Human Services and its Department of Health, which are required to cite matters needing correction to be in compliance with administrative obligations. In 2022, 4 correction orders were issued against MSOP. However, rather than curing these problems and more carefully obeying all requirements, the number of clinical practices that have perpetuated the snail's crawl toward release for all confinees is notorious on its own. In 2022 and 2023, at least some progress (50%) was made in terms of writing some revision to MSOP "Treatment Philosophy and Design" as part of MSOP's New Employee Orientation. The current state of that document is unknown. However, whether finished on paper or not, at present in mid-2025, apparent to date.
- As of the end of 2022, MSOP had reduced the past higher percentage of confinees in Phase 1 of treatment, apparently promoting most to Phase 2 (which by then swelled to hold 500 confinees). However, Phase 3 of treatment (still only conducted in St. Peter) still held only 43 confinees, presenting a bottleneck of blockade proportions to further advancement of confinees.

The Minnesota Sex Offender Program (MSOP) Annual Report 2023 (issued March 25, 2024) does not contain better news on remained at 17.3 during 2023; worse, the clinical department vacancy rate was 24.1% in that same year. Transfer orders increased over 2022 rates only nominally. The number of those being granted final discharge reduced from 3 during 2022 to 2 in 2023 – essentially presenting the equivalent of a steel exit

MSOP treatments fell from 43 to 32, suggesting that the logjam at this stage of treatment has worsened, squeezing

off throughput and partly explaining the reduction in releases and final discharges. This reduction was regular by quarters throughout 2023, suggesting this is not due to any sudden catastrophic event, but rather just chronic failure to continue at steady progress.

- The number of available CPS beds did not increase at all during 2023, posing yet another blockage to advancement and release.

This author would like to present to the reader comparative figures for 2024 (the last year for which the PEN award was baselessly bestowed on MSOP). However, that 2024 Annual Report either does not exist or is now being withheld internally by MSOP from release to legislators, politicians, and the general public due to reluctance to acknowledge the continuing cavalcade of MSOP failure and apparent refusal to change to reverse that chronic failure. The inference that MSOP leadership likes things just the way they are lies heavily in the air.

Case Shows That No Public Official Is Above the Law.

The Marshall Project: "'Pick of the News" (Andrew Cohen, Ed), June 16, 2025, reports that "Former Illinois House Speaker Mike Madigan was sentenced on Friday to more than seven years in prison and a \$2.5 million fine following his bribery and racketeering conviction earlier this year." (Source: <https://www.marshallproject.org/en-us/news/2025/6/16/mike-madigan-sentenced>)

MSOP Provisional Release "Roadshow" Shows Hyper-Restriction Overkill, Waste, & Why the SRB-CAP Process Can Only Drag Feet.

On Tuesday, June 17, 2025, several central-office MSOP officials presented two showings of a provisional release (PD) live "Roadshow" to interested confinees. Such containing the latest updates about PD. While numerous new and changed facts about PD were presented this time, the overall news is how little of the fundamental situation has actually changed in any meaningful way for the better.

change of the term for unauthorized departures from PD from "absconding" to the curious application of the word "elopement"

(even though a romantic partner and an unsanctioned marriage are almost never involved).

The formal shift from ultimate administrative control over MSOP by the Commissioner of the Minnesota Department of Human Services to the new "agency" (not "Department"), Direct Care and Treatment, occurred on July 1, 2025 without any known hitches or glitches. In brief recap, this change is a first in Minnesota state government in abandoning the traditional departmental structure, headed by a czar-like chief usually referred to as the "commissioner."

Instead, Direct Care and Treatment (DCT) will be headed by an "executive board" (comparable in function to a corporation's "board of directors" and primarily in charge of setting and altering policy). Just as in a corporation, Marshall Smith will be the "Chief Executive Officer" (CEO), responsible for governing all day-to-day operations of DCT and administering, through discretionary decisions, the policies set by the years.

In the June 17th Roadshow, MSOP Executive Director Nancy Johnston gave an example of this distinction in DCT Board and CEO responsibilities by saying that, with regard to PD, MSOP answers to the Board as to funding requests for costs of PD, but that specific decisions over PD releases will be made by CEO Smith. This last clause was a little surprising, since specific decisions to grant or deny PD to any specific petitioner, confinee, or releasee, is simply one of policy as to making releases, as an aggregate matter, possible as a practical matter through functional choices such as expanding the supply of housing to accommodate newly released PDs.

One example of insufficient housing options and other practical limitations on PD appeared through observations by Scott Halvorson, citing that "over 100" PD "orders" (by CAP) exist, yet conceding later in the Roadshow that the actual number of PDs currently on release is only 65. The Roadshow presenters complained of inadequate

Reference was made to the fact that MSOP itself must approve each housing site. It appears that most proposed sites placement is under consideration, the municipality/county in which the proposed housing is located is contacted after MSOP has vetted that site to ask if that local government has any restriction barring the placement or any political opposition to it

Of course, the likelihood greatly favors a response posing some existing restriction or
(Continued on page 10)

some political objection that is suggested will ripen into such bar; no local government is likely to welcome sex offenders. So this de facto MSOP standard of each such proposed placement being 'all right' with local government effectively subjects each placement to an extralegal veto power on the part of every local government that can ever be proposed for such PD placement. Essentially, whether deliberately or not, MSOP torpedoed every possible PD placement in this way. This is not failure by *force majeure*, it is functionally invited failure.

Adding complications to such practical matters of a 'physical first' nature, every candidate for PD must first go through the ECRC process again, as they did if in prison before commitment when anticipating parole to "intensive supervised release" (ISR). As then, the core determination made by the ECRC in the pre-PD context of MSOP is to set the risk-of-re-offense "Tier" level for the prospective releasee.

This Tier 1 through 3 system (with Tier 3 for those thought to present the highest risk of sexual re-offense) establishes, among other things, whether community notification is required as to that releasee and by what means it will be carried out. This tier rating system can also play a role in determining where one may reside, and has been used even to veto certain jobs that a releasee may wish to apply for. By statute, a releasee cannot seek a new ECRC hearing until at least three years have passed since release, no matter how well-established the releasee becomes within the first few months after release. This is another patent example of add-on punishment inflicted as a supposed 'collateral consequence' of a sex-offense conviction.

The entirety of the Tier system, created by two angry congressmen without any consultation with criminology experts concerning sexual recidivism or its prevention, has been regularly criticized by criminologists as counter-effective by actually so blocking effective "reintegration" of former sex offenders into the fabric of community life that it actually makes further crimes more likely.

Yet, for the time being, this ill-conceived and adverse-outcome inflicting system continues to hold sway over all decisions as to released sex offenders, potentially extending even decades into the future, long after any releasee from MSOP will have long-since expired any correctional parole and MSOP's own PD. It is the spanner jammed in the works that no one has the political courage to extricate and discard.

In a blatant act of simply 'piling on,' a Minnesota statute dictates that, regardless of the "Risk Level" tier of any given releasee, the police agency of one's place of residence/proposed residence gets to decide whether to hold a community notification meeting – even as to a Tier 1 releasee – and to treat that releasee as a Tier 2 or Tier 3 person for up to the expiration of four years post-release (from the date of the CAP release order).

This infliction of the burdens of such high tier status beyond the statutory formulation of the criteria to be applied by the ECRC can only be read as giving local police a

right to banish/exclude any sex offender they wish from their municipality/county. Some locales have a standing policy of barring any Tier 3 releasee from residing anywhere within their boundaries. This 'police decision' is simply the way they skirt around the decision by the state Supreme Court barring an official ban by Dayton, MN of released sex offenders from 100% of all residences in the city. This is simply sanctioned bias to permit blocking one from living in what is supposed to be supervised freedom.

Currently, all MSOP PDs must start PD in a halfway house-type placement for the first 12 to 18 months of PD. This roughly approximates "Tier 1" of the MSOP PD program. In all, PD in MSOP consists of Tiers 1 through 5 (a confusing duplication of nomenclature used in the ECRC process described above). Unless CAP ends PD earlier, all five tiers must be completed by the releasee for MSOP to support an end to PD. Any PD releasee not living in the halfway house-type facilities must pay the whole amount of their rent. Further, all PD releasees must participate in treatment as directed by MSOP while on PD, and must pay the whole cost of such treatment.

MSOP uses two risk assessment tools to make determinations of how long one must stay in any given tier. One of these, the Static-99R, is a checklist of "static" factors (that is, factors of one's criminal history and other historical facts not possible to change, with the only exception moving forward in the future of living with a spouse/lover for years or simply getting older in two jumps in the decades of ages 50s and 60s, respectively, reflecting lesser re-offense risk). After the halfway house stage of Tier 1, Tier 2's duration is a minimum of 10 months. Only after that, in Tier 3 can one request permission to apply for a driver's license and for a fully independent living setting. Tier 4 has a minimum duration of 6 months, and Tier 5 lasts until Final Discharge is granted. In all, past PD "roadshows" have estimated that it takes about 5 years (if not more) to complete PD.

Interestingly, of the 65 people in PD currently, only 32 have full-time employment. Halvorson cited retirement, illness, disability, and infirmities of aging as chief reasons why the others do not have such employment. He conceded that many of these unemployed were actually in assisted living facilities, if not skilled nursing facilities.

Although such persons have as much right to PD as others, it is misleading to count these shut-ins in the same total as those who are hale and hearty and employed or employable. When these shut-ins are deducted, the limited extent of MSOP's PD as currently practiced becomes much clearer. Effectively the overall PD picture is one of very limited approval of those still young or healthy enough to work, as opposed to those not. Even those who are in senior-citizen status appear to only be gaining PD if they are also medically decrepit in some particular way. This appears to be a deliberate restriction of PD in this older category only to those unable to fully enjoy life due to such physical limit(s). This restriction is hardly what PDF was intended for.

Another artificial restriction limits the use of PD currently. MSOP limits the number of PD supervisees to ten per PD agent. Currently, there are only 6 PD agents for the entire state. MSOP divides the state currently into east and west portions, roughly divided by Interstate Highway 35. This lack of sufficient agents artificially restricts the number or releases in each of these two vast portions of the state. While mention was made in this Roadshow to plans to transect these two portions into north and south sub-portions, no statement was made about plans to hire any more agents to supervise PD releasees. Until that happens, the number of PD releases would appear to be frozen in the rough limit of that same 65.

If all releasees on PD graduated to final discharge (FD) status like clockwork (they do not), this would reflect a rate of over 12 per year on average achieving FD. However, the actual rate for gaining FD is only between 4 and 5 releasees per year. This includes those who are sometimes granted FD directly from CAPS status or even upon first CAP application, with no PD period at all. Hence a more reasonable number for those 'graduating' from PD to FD is only between 2 and 3 per year (see lead article in TLP # 9:7).

Thus, far more end their tenure on PD by having it revoked. MSOP says that there have not been any revocations for sexual crimes (which, again, shows that these releasees do not present any "danger" to the community.)

Hence, revocations are either for other crimes or for technical violations of conditions of PD. The high percentage of revocations for technical violations suggests that the rules of PD are probably too burdensome and 'picky' in their administration.

On the whole, MSOP's lack of more than a comparative trickle of throughput to PD and to FD is powerful evidence of MSOP's failure of mission. Contrary to its Mission Statement, there is no meaningful "opportunity" for those committed to achieve release even merely to PD, much less the vanishingly infinitesimal chance of ever making it to FD.

If —

by Rudyard Kipling

If you can keep your head
when all about you
Are losing theirs
and blaming it on you,

If you can trust yourself
when all men doubt you,
But make allowance for
their doubting too;

If you can wait and
not be tired by waiting,
Or being lied about, don't deal in lies,
Or being hated
don't give way to hating,
And yet don't look too good,
nor talk too wise;

If you can dream –
and not make dreams your master;
If you can think –
and not make thoughts your aim,
If you can meet with
Triumph and Disaster
And treat those two
imposters just the same;

If you can bear to hear
the truth you've spoken
Twisted by knaves
to make a trap for fools,
Or watch the things
you gave your life to, broken,
And stoop and build 'em up
with worn-out tools:

If you can make one heap
of all your winnings;
And risk it one turn
of pitch-and-toss,
And lose, and start again
at your beginnings
And never breathe a word
about your loss;

If you can force
your heart and nerve and sinew
To serve your turn
long after they are gone,
And so hold on when there
is nothing in you
Except the Will which says
to them: 'Hold on!'

If you can talk with crowds
and keep your virtue,
Or walk with Kings –
nor lose the common touch,
If neither foes nor
loving friends can hurt you,
If all men count with you,
but none too much;

If you can fill
the unforgiving minute
With sixty seconds' worth
of distance run,
Yours is the earth and
everything that's in it,
And – which is more –
you'll be a Man, my son!

the Legal Pad

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