

TREATMENT OVERVIEW

Minnesota Sex Offender Program

Issue Date: 8/4/15 Effective Date: 9/1/15 Policy Number: 215-5005

POLICY: The Minnesota Sex Offender Program (MSOP) provides comprehensive sex offender treatment to civilly committed sexual abusers. The MSOP Program Theory Manual (215-5005d, attached) outlines the program's treatment model, approach and design.

MSOP operates treatment sites in Moose Lake and St. Peter and a collaborative treatment program in the Minnesota Correctional Facility –Moose Lake (MSOP-DOC).

AUTHORITY: Minn. Rule 9515.3040, Subp. 2.

APPLICABILITY: Minnesota Sex Offender Program (MSOP), program-wide

PURPOSE: To promote public safety by providing comprehensive treatment and reintegration opportunities for civilly-committed sexual abusers.

DEFINITIONS:

Reintegration – a transitional period designed to provide opportunities for clients to apply their acquired skills and master increasing levels of privileges and responsibility while managing risk factors and maintaining public safety.

Sex offender treatment – a comprehensive and integrated set of planned and organized therapeutic experiences and interventions intended to improve the prognosis, function, and/or outcome of clients to reduce the risk of sexual re-offense, or other sexually abusive/aggressive behavior, by assisting clients to adjust to and deal more effectively with their life situations.

Treatment Goal Matrix (Goal Matrix) – a goal structure for treatment reflecting the criminogenic needs of sex offenders as reflected in research.

Treatment Support Staff – staff members whose primary responsibility is to maintain a secure and orderly environment supportive of treatment by performing such duties as escorting persons, observing persons' behavior, directing group activities on the living units and providing feedback to the treatment team on client observations.

Treatment team – a group of MSOP staff providing direct services for MSOP clients in a coordinated manner, led by the client's primary therapist and including: the client, unit staff, sex offender treatment staff (including treatment psychologists and supervisors), therapeutic recreation staff, vocational services staff, health services staff, education services staff, reintegration specialist (Community Preparation Services only) and others as/when appropriate. At a minimum the treatment team must include the client, the client's primary therapist, a licensed mental health professional (as defined in Minn. Stat. §245.462, subd. 18) or license-eligible psychologist, a registered nurse (as needed), and a member of the treatment support staff. When medications or medical treatment is prescribed, a licensed physician, an advance practice registered nurse or a physician's assistant must also provide input.

PROCEDURES:

A. Treatment Model and Approach

1. MSOP programming is grounded in several contemporary treatment models, including, but not limited to, cognitive-behavioral therapy, group psychotherapy, and relapse prevention. In addition, programming is influenced by professional psychological literature in the areas of risk/needs/responsivity, psychotherapy, and stages of change, with additional philosophical influence from the “Good Lives” model. Creative approaches such as role-play, demonstration, and creative arts therapies reinforce treatment concepts and address individual learning styles.
2. Each MSOP client has an individualized treatment plan (ITP) (215-5007a-3050, Phoenix Report) defining treatment goals to assist the client in making meaningful change and progressing through the Treatment Goal Matrix (215-5005a, attached). The assigned primary therapist provides each client with the Goal Matrix to assist in treatment engagement.
3. MSOP has three phases of treatment as outlined in MSOP Division Policy 215-5010, “Treatment Progression.”
4. Clients acquire skills through active participation in group therapy and psychoeducational groups. Clients are provided opportunities to demonstrate meaningful change through participation in rehabilitative therapies programming, including education classes, therapeutic recreation activities and vocational programming. Staff observe and monitor clients in all aspects of daily living to assess their progress in making and maintaining meaningful personal change and consistently applying treatment concepts across various settings.
5. MSOP utilizes various assessments (including, but not limited to, polygraphs, penile plethysmographs, Abel Assessment of Sexual Interest-2, and other neuropsychological or psychological assessments) to assist staff in treatment planning and to assist clients in making meaningful change.

B. Treatment Design

1. MSOP clients choosing to engage in treatment participate in a sexual offender assessment, setting the foundation for their individualized treatment plans. Staff place clients in treatment groups based on their needs identified in the ITP (see also MSOP Policy 202.010, “Client Placement”). MSOP provides sex-offender treatment to meet the needs of all clients.
2. Each MSOP site contributes to the mission of MSOP by specializing in different components of the treatment process.
 - a) The Moose Lake site is the reception facility for MSOP and provides treatment for clients in the earlier phases of treatment, clients requiring specialized care or programming, and clients still involved in the court commitment process.
 - b) The St. Peter site has the Alternative Program (see B.3.b), below) and provides services for clients in the later phases of treatment through reintegration.
 - c) The MSOP-DOC site provides sex offender treatment for offenders committed to the Minnesota Department of Corrections housed at the Minnesota Correctional Facility-Moose Lake.
3. MSOP Specialized Living Units at Moose Lake and St. Peter:
 - a) Admissions – houses clients newly admitted to MSOP and/or involved in commitment proceedings and not yet committed by the courts.

- b) Alternative Programming Unit – houses clients with compromised executive functioning who may have cognitive impairments, traumatic brain injuries and/or learning disabilities preventing them from fully participating in conventional programming.
- c) Assisted Living Unit – houses medically compromised clients requiring specialized care.
- d) Behavior Therapy Unit – houses clients demonstrating behaviors disruptive to the general population and/or affecting the safety of the facility. Clients on this unit are treated with the goal of transitioning to their assigned living unit once the treatment-interfering behaviors are successfully addressed. (See the Unit Omega Handbook, 215-5005c, attached).
- e) Conventional Programming Units – houses clients participating in sex-offender treatment.
- f) Corrective Thinking Unit – houses clients presenting with unique treatment needs and generally higher antisociality.
- g) Mental Health Unit – houses clients with significant mental health concerns resulting in persistent emotional instability.
- h) Young Adult Unit – generally houses clients between 18-25 years old who are not appropriate for the Alternative Programming or the Corrective Thinking Units.

C. Treatment Structure

1. Designated clinical staff complete assessments of clients upon admission to the MSOP (see MSOP Policy 202.100, “Admission to the MSOP”).
2. Clients expressing interest in beginning treatment participate in a sex-offender assessment. Information from this assessment is incorporated into the ITP (see MSOP Division Policy 215-5007, “Clinical Documentation”). The assigned primary therapist prepares the ITP in collaboration with the client, based on the client’s identified treatment needs.
3. The primary therapist, with input from the client, is responsible for assigning the client to core therapy groups and psychoeducational groups based on their individual treatment needs.
4. Clients progress through treatment by adhering to their ITPs, actively participating in treatment, successfully completing treatment assignments, and demonstrating changes in their thinking and behaviors. The treatment team reviews and assesses each client’s progress in treatment quarterly and annually. (See MSOP Division Policy 215-5007, “Clinical Documentation.”) Each client’s self-assessment is incorporated into the treatment progress review. The primary therapist updates the client’s ITP at least annually or as clinically indicated.
5. Reintegration programming
Clients are provided gradually increased liberties and opportunities to assist in deinstitutionalization and generalize treatment skills, which maintain change and manage risk factors. Clients are reintroduced to the outside community through progressive levels of privileges as outlined in MSOP Policy 600.020, “Client Privilege Attainment – St. Peter”,

MSOP Policy 600.030, "Programming Outside the Secure Perimeter" and MSOP Policy 602.010, "Community Preparation Services."

REVIEW: Annually

REFERENCES: MSOP Division Policy 210-5200, "Civil Commitment Process" MSOP Policy 203.010, "Treatment Progression"
MSOP Policy 202.010, "Client Placement"
MSOP Policy 202.100, "Admission to the MSOP"
MSOP Policy 203.060, "Special Review Board"
MSOP Division Policy 230-5100, "MSOP Departure"
MSOP Policy 600.020, "Client Privilege Attainment – St. Peter" MSOP Policy 500.060, "Psychiatric Services"
MSOP Division Policy 215-5007, "Clinical Documentation"
MSOP Policy 600.030, "Programming Outside the Secure Perimeter"
MSOP Policy 602.010, "Community Preparation Services"
MSOP Policy 103.042, "Supervision of License-Eligible Psychologists"
Minn. Rule 2960.0020, subp. 58

ATTACHMENTS: Treatment Goal Matrix (215-5005a)
Unit Omega Handbook (215-5005c)
MSOP Program Theory Manual (215-5005d)

SUPERSESSION: MSOP Policy 203.005, "Treatment Overview," 5/6/14.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

/s/
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