Nos. A21-0042,
A21-0043

STATE OF MINNESOTA
IN SUPREME COURT

Ricky Lee McDeid, Plaintiff-Appellant,

and

Shane P. Garry, Plaintiff-Appellant,

v.

Nancy Johnston, CEO/Director, Minnesota Sex Offender Program, an agency of the State of Minnesota; and Jodi Harpstead, Commissioner, Department of Human Services, an agency of the State of Minnesota,

Defendants-Respondents.

BRIEF OF LEGAL AND TREATMENT EXPERTS MICHAEL H. MINER AND ERIC S. JANUS AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS

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STATEMENT OF INTEREST[1]

Amici are professors with expertise in the provision of treatment to individuals who have been civilly committed. Amici have an interest in clarifying the importance of treatment that meets current professional standards to the constitutional legitimacy and efficacy of the Minnesota Sex Offender Program. Amici's interest in this matter is public, as the outcome of this case will impact the constitutional protections afforded to Minnesotans.

Michael H. Miner, Ph.D., L.P. is Professor of Family Medicine and Community Health and Research Director for the Institute for Sexual and Gender Health at the University of Minnesota. He conducted numerous studies of adolescents and adults who have committed sexual offenses, including explorations of etiology, treatment efficacy, risk assessment, and public policy. Dr. Miner coordinated adult sex offender treatment at Program for Human Sexuality for 10 years and conducts psychosexual evaluations of adolescents and adults within the criminal justice and child protective system. He is past President of the Association for the Treatment of Sexual Abusers and past Vice President of the International Association for the Treatment of Sexual Offenders.

Eric S. Janus is former President and Dean (Emeritus), and Director of the Sex Offense Litigation and Policy Resource Center at Mitchell Hamline School of Law. He is co-author of several books on the law and policy of civil commitment, and several

[1] Pursuant to Minnesota Rule of Court 129.03, Amici certify that this brief was not authored, in whole or in part, by counsel for a party to this litigation and that no person or entity, other than Amici or their counsel, made a monetary contribution to the preparation or submission of this Brief.

articles in peer reviewed journals on the same subject. He has taught mental health law for a number of years.

INTRODUCTION

Since its inception in 1994, the constitutionality of the Minnesota Sex Offender Program ("MSOP") has been repeatedly questioned and narrowly defined by state and federal caselaw. Questions of constitutionality arise for a critical reason: although MSOP purports to provide temporary confinement to facilitate treatment and safe re-entry into the community, MSOP's practices belie this intent.

Instead of providing evidence-based treatment and facilitating safe community re-entry, MSOP has developed an alarming record of admission and retention. As of November 30, 2021, there were 740 civilly committed individuals in MSOP, a far higher per capita rate of civil commitment than any other comparable state program.[2] Perhaps even more alarming, only 14 clients have ever been fully discharged and are no longer under the jurisdiction of MSOP.[3] Another 33 clients have been provisionally discharged but remain under state supervision,[4] whereas at least 72 clients have died in MSOP custody.[5] By contrast, Wisconsin's civil commitment program for "Sexually Violent

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[2] *See Minnesota Sex Offender Program Statistics*, Minn. Dep't of Hum. Servs., https://mn.gov/dhs/people-we-serve/adults/services/sex-offender-treatment/statistics.jsp (last updated Nov. 30, 2021). *See also infra* note 16.

[3] *Id.*

[4] *Id.*

[5] Chris Serres, *Hunger Strike Takes Toll of Detainees at Minnesota Treatment Center for Sex Offenders*, STAR TRIB. (July 12, 2021), https://www.startribune.com/hunger-strike-takes-toll-on-detainees-at-minnesota-treatment-center-for-sex-offenders/600077394/?refresh=true.

Persons" has fully discharged 135 individuals[6] and currently has 73 individuals living in the community on supervised release.[7] At MSOP, however, the average patient, who has already served and completed a full criminal sentence for their misconduct, remains in secure confinement for decades with no clear path to community reentry. Over the last twenty-seven years, MSOP has shown that its "indefinite" deprivations of liberty are, more often than not, a life sentence.

Despite the serious loss of personal liberties at stake, researchers have found that civil commitment schemes like MSOP do very little to reduce sexual violence at large. In fact, a 2013 study assessing the effect of Sexually Violent Predator ("SVP") laws on sexual abuse rates found that such laws "have had no discernible impact on the incidence of sex crimes . . . a result that carries enormous constitutional significance."[8] This lack of impact may be partially explained by patterns of sexual assault more broadly. Although media coverage often portrays recidivist offenders as commonplace dangers lurking in our communities, studies have shown that 86% of those imprisoned for sex crimes had no prior sex offense convictions.[9] This means that programs like MSOP, designed to

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[6] *See* Sex Offender Civil Commitment Programs Network (SOCCPN), *SOCCPN Annual Survey of Sex Offender Civil Commitment Programs 2020* (Oct. 20, 2020), on file with author.

[7] *See Supervised Release Program: FAQs*, Wisconsin Dep't of Health Servs., https://www.dhs.wisconsin.gov/sr/faqs.htm (last updated Dec. 14, 2021).

[8] Tamara Rice Lave & Justin McCrary, *Do Sexually Violent Predator Laws Violate Double Jeopardy or Substantive Due Process? An Empirical Inquiry*, 78BROOK. L. REV.. 4, 1396 (Summer 2013).

[9] Eric S. Janus, *Failure to Protect: America's Sexual Predator Laws and the Rise of the Preventive State* 43 (2006) (citing Lawrence A. Greenfield, U.S. Dep't of Just., Bureau of Just. Stat., *Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault* 22 (1997)).

exclusively address recidivist sexual violence, only address a sliver of a much broader social problem.

Even focusing exclusively on recidivist sexual violence, state civil commitment programs show little impact on sexual violence prevention. Contrary to the often quoted and erroneous claim that recidivism rates of those convicted of prior sex offenses are "frightening and high," as a group, those convicted of sex offenses have one of the lowest recidivism rates across all offender categories[10] and the incapacitation effects of civil commitment programs like MSOP are minimal.[11] Additionally, we now understand that as individuals convicted of sex offenses age, their likelihood of re-offense drops, just like other categories of offender.[12] This pattern remains true for "high risk offenders."[13] Sixteen percent of MSOP's population is comprised of individuals over 65 years of age, including at least one 88 year old client.[14] Although these individuals have a diminished risk of re-offense, many in MSOP's elderly population remain isolated in MSOP's secure

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[10] *See* Ira Mark Ellman & Tara Ellman, *"Frightening and High": The Supreme Court's Crucial Mistake About Sex Crime Statistics*, 30 CONST. COMMENT. 495, 504 (2015); *see also* Mariel Alper & Matthew R. Durose, Dep't of Just., Bureau of Just. Stat., *Recidivism of Sex Offenders Released From State Prison: A 9-Year Follow-Up (2005-14)* (May 2019), https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6566.

[11] *See* Grant Duwe, *To What Extent Does Civil Commitment Reduce Sexual Recidivism? Estimating the Selective Incapacitation Effects in Minnesota*, 42 J. Crim. Just. 2, 193–202 (2014).

[12] R. Karl Hanson, *Recidivism and Age: Follow-Up Data from 4,673 Sexual Offenders*, 17 J. INTERPERSONAL VIOLENCE 1046, 1056 (2002); Lave & McCrary, *supra* note 8, at 1423.

[13] *See* Robert A. Prentky & Austin Lee, *Effect of Age-at-Release on Long Term Sexual Re-offense Rates in Civilly Committed Sexual Offenders*, 19 SEXUAL ABUSE 43, 44 (2007).

[14] *See Minnesota Sex Offender Program Statistics*, *supra* note 2.

facilities. Despite data revealing the infrequency of recidivist sexual abuse and the inverse correlation between age and recidivism, facts illustrating the misguided nature of civil commitment programs like MSOP have historically been ignored, discounted, and, at times, suppressed.[15]

In short, in addition to the serious questions of efficacy that apply to any sex offender civil commitment scheme, plagued by its unclear path to program completion and outsized commitment rate, MSOP stands out nationally[16] and internationally[17] as a problematic involuntary civil commitment regime.

In this case, the Court must evaluate whether respondents Nancy Johnston, CEO/Director of MSOP, and Jodi Harpstead, Commissioner of the Department of Human

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[15] *See* Tamara Rice Lave & Franklin E. Zimring, *Assessing the* Real *Risk of Sexually Violent Predators: Doctor Padilla's Dangerous Data*, 55 AM. CRIM. L. REV. 705, 720–27 (2018) (using internal memoranda and emails to describe the efforts of the California Department of Mental Health to suppress a serious and well-designed study that showed just 6.5% of untreated sexually violent predators were arrested for a new sex crime within 4.8 years of release from a locked mental facility).

[16] *See Karsjens v. Jesson*, 109 F. Supp. 3d 1139, 1148 (D. Minn. 2015), *rev'd and remanded sub nom. Karsjens v. Piper*, 845 F.3d 394 (8th Cir. 2017) (recognizing that at the time of decision, in 2015, Minnesota had the highest per-capita population of civilly committed sex offenders in the nation); *see also* Sex Offender Civil Commitment Programs Network (SOCCPN), *SOCCPN Annual Survey of Sex Offender Civil Commitment Programs 2020* (Oct. 20, 2020), on file with author, (SOCCPN's 2020 Annual Survey lists Minnesota as the state with the highest per capita civil commitment rate at 128.9 commitments per million people. In 2020, the second and third highest per capita rates respectively are 91.7 commitments per million in Kansas, and 50.1 commitments per million in Virginia).

[17] *See Sullivan v. The Gov't of the U.S. & the Sec'y of State for the Home Dep't*, [2012] EWHC 1680 (Admin) [28] (Eng.), http://www.bailii.org/ew/cases/EWHC/Admin/2012/1680.html (extradition case finding that admission to Minnesota's civil commitment program would constitute a "flagrant denial" of an individual's rights under Art. 5.1 of the European Convention on Human Rights).

Services, had a "clearly established" obligation to timely transfer Appellants Ricky Lee McDeid and Shane P. Garry after Commitment Appeal Panel ("CAP") orders directed transfer to a less-restrictive facility for Community Preparation Services ("CPS").

Without directly addressing the question before the Court of whether state officials are liable for damages due to the delay in implementing court-ordered treatment, Amici note that two constitutional principles underlying the legitimacy of state civil commitment regimes must impact the Court's analysis. *First*, where a state civil commitment regime describes its purpose as treatment-based, a failure to provide adequate treatment undermines constitutional legitimacy by raising concerns that the Program's true purpose is a forbidden one – further punishment of a reviled and stigmatized group. *Second*, state and federal case law place a constitutional durational limit on civil commitment, rendering continued confinement immediately unconstitutional where a permissible commitment purpose is no longer being served. These two principles are well established in state and federal case law and were fundamental to MSOP's design. Further, promises of conformity with these principles were repeatedly made by the State, and relied on by courts, in litigations challenging the constitutionality of MSOP.[18] The State and its actors involved in the supervision of MSOP are well aware of these principles.

[18] *See Call v. Gomez*, 535 N.W.2d 312, 319 (Minn. 1995); *Linehan III*, 557 N.W.2d 171, 181 (Minn. 1996), *cert. granted, judgment vacated sub nom. Linehan v. Minnesota*, 522 U.S. 1011 (1997); *Karsjens v. Piper*, 845 F.3d 394, 410–11 (8th Cir. 2017).

In this case, the State's failure to timely transfer Appellants to CPS was no minor oversight, nor was it short-lived. The State and its actors disobeyed a court-order to implement less restrictive treatment to address the individualized needs of the Appellants for 26 months in one case, and 30 months in the other. In doing so, the State denied Appellants appropriate treatment and failed to meet contemporary professional standards. The State's conduct calls into question the constitutionality of continued detention for all MSOP clients currently held involuntarily without access to appropriate treatment. As a final matter, Amici note that the State's conduct in delaying client transfer to CPS simultaneously increases the cost of MSOP while reducing its effectiveness in serving the State's legitimate public safety goals.

For the reasons stated above, Amici join Appellants in their argument that Respondents' qualified immunity defense should be rejected, and this case should be remanded for discovery.

ARGUMENT

I. Failure to Provide Adequate Treatment Undermines Constitutionality of MSOP

Involuntary civil commitment is a "massive curtailment of liberty" implicating fundamental rights such as the "freedom from physical restraint." *Humphrey v. Cady*, 405 U.S. 504, 509 (1972); *Foucha v. Louisiana*, 504 U.S. 71, 86 (1992). Recognizing the liberty interests at stake, courts have taken pains to distinguish civil commitment from

further incarceration with punitive or deterrent intent.[19] The provision of treatment has been central to this distinction.[20]

In *Kansas v. Hendricks*, evaluating the constitutionality of Kansas's civil commitment scheme, the Court considered Kansas's statutory "obligation" to provide treatment in assessing whether the state civil commitment scheme was retributive or served goals of general deterrence. 521 U.S. at 367. Concurring with the plurality opinion in *Hendricks*, Justice Kennedy noted, "If the object or purpose of the Kansas law had been to provide treatment but the treatment provisions were adopted as a sham or mere pretext, there would have been an indication of the forbidden purpose to punish." *Id.* at 371 (Kennedy, J., concurring).

Similar to the civil commitment scheme in *Hendricks*, MSOP is statutorily obligated to provide proper and appropriate treatment to the patients forcibly confined under the Act. For example, Minnesota Statute Chapter 253D.01 is referred to as the "Minnesota Commitment and *Treatment* Act"; the MSOP facilities are referred to as "Secure *treatment* facilities"; Chapter 253B.03 lays out the "Rights of *Patients*" to a "*Treatment plan*" noting that "[a] patient receiving services under this chapter has the right to receive *proper care and treatment*, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary"; and even the MN

[19] *See Kansas v. Hendricks*, 521 U.S. 346 (1997).
[20] *See Linehan III*, 557 N.W.2d 171, 181 (Minn. 1996) *cert. granted, judgment vacated sub nom. Linehan v. Minnesota*, 522 U.S. 1011 (1997); *Call v. Gomez*, 535 N.W.2d 312, 319 (Minn. 1995).

Department of Human Services website refers to civilly committed individuals as "*clients*" and describes the treatment, rehabilitative services, and process toward release.

Indeed, the State actively characterized MSOP as a treatment program before this Court in *Linehan III*, 557 N.W.2d at 181, and this Court's approval of MSOP turned heavily on that discussion. This Court stated, "So long as civil commitment is programmed to provide treatment and periodic review, due process is provided." *Id.* (quoting *In re Blodgett*, 510 N.W.2d 910, 916 (Minn. 1994)). Based on these representations, MSOP is constitutionally legitimate only so long as the nature and duration of commitment are reasonably related to the treatment purpose for which the individual is committed.[21]

In keeping with these principles, and as the Southern District of Illinois recognized in a recent decision, "[a]ctual treatment of the civilly confined is what separates commitment from punishment and incarceration." *Howe*, 2021 WL 4050852, at *11. "Without adequate treatment designed to effectuate ultimate release, a civil commitment program is nothing more than a de facto prison disguised as a mental health facility." *Id.*

As described further below, the State's conduct in this case was a radical departure from professional treatment standards. The State allowed Appellants' treatment plans to stall, and progress toward release to stagnate, not for days or months, but for years while continuing to restrict their freedom of movement in a prison-like setting. Such practices

[21] *See Foucha*, 504 U.S. at 79; *Jackson v. Indiana*, 406 U.S. 715 (1972); *Call*, 535 N.W. at 318; *Lidberg v. Steffen*, 514 N.W.2d 779, 783 (Minn. 1994); *Howe v. Godinez*, No. 14-CV-844-SMY, 2021 WL 4050852, at *10 (S.D. Ill. Sept. 6, 2021).

are in direct conflict with MSOP's treatment purpose and statutory requirements. For that reason, claims that such requirements were not "clearly established" are not credible. In short, this case involves persistent State disregard for MSOP's most basic program requirements, calling into question the Program's animating purpose and constitutional validity.

II. Years-Long Delay in Providing Treatment Violated the "Durational Limit" Applied to Civil Commitment

In tandem with MSOP's obligation to provide adequate treatment, the State and its actors are constrained by a well-known constitutional principle, the "durational limit." The durational limit establishes that civil commitment must end *immediately* when it is no longer justified by a permissible purpose. *Kansas v. Hendricks*, 521 U.S. 346, 368 (1997).

In the context of MSOP, that means that once MSOP clients can appropriately be treated in a less restrictive environment, their continued detainment in a high security prison-like setting becomes unconstitutional.[22] The State and its actors are well-aware of this guiding principle which served as the basis for the Special Review Board ("SRB") and Commitment Appeal Panel ("CAP") review. Those review processes were created to ensure that MSOP clients could be transferred to less-secure environments and ultimately

[22] "[O]nce a person is committed, his or her due process rights are protected through procedural safeguards that include . . . the opportunity to petition for transfer to an open hospital." *Call v. Gomez*, 535 N.W.2d 312, 318–19 (Minn. 1995) (citing *In re Blodgett*, 510 N.W.2d 910, 916 (Minn. 1994)).

safely re-introduced to the community when such confinement was no longer necessary for their treatment or for public safety.

State assurances of MSOP's procedural protections allowing Appellants to transfer to a less secure facility were relied on by the Eighth Circuit in *Karsjens v. Piper*, allowing MSOP's civil commitment structure to survive a challenge in federal court.[23] 845 F.3d 394, 410–11 (8th Cir. 2017). This Court similarly approved of MSOP only "[s]o long as the statutory discharge criteria are applied in such a way that the person subject to commitment . . . is confined for only so long as he or she continues both to need further inpatient treatment and supervision for his sexual disorder and to pose a danger to the public . . . ." *Call*, 535 N.W.2d at 319; *see also Linehan III*, 557 N.W.2d 171, 181 (Minn. 1996) *cert. granted, judgment vacated sub nom. Linehan v. Minnesota*, 522 U.S. 1011 (1997) (stating that due process is provided in the civil commitment process where there is periodic review). It is not enough, however, for MSOP's promise of periodic review to exist only in its litigation representations to this and other courts. Where the statutory mechanisms for review and release are nothing more than "window dressing," MSOP's civil commitment structure becomes an illegitimate "sham." *See Foucha v. Louisiana*, 504 U.S. 71, 114 n.10 (1992) (Thomas, J., dissenting); *see also Folson*.

The State and its actors violated the durational principle by keeping Appellants detained in an isolated and restrictive prison-like setting despite a court order directing

[23] *See also In the Matter of the Civil Commitment of: Al Stone Folson*, No. AP19-9153, at 8 (Commitment Appeal Panel Dec. 2, 2021) (Contempt Order) ("Folson"), provided in the Addendum to this Brief at p.1

their transfer to a less-restrictive environment. This constitutional requirement has been clearly established for almost fifty years.[24] It is the very reason our law has clear procedures for review. It is simply not credible that the State and its officers were unaware of this constitutional principle. Permitting the State's conduct to go unaddressed would reveal MSOP's review process to be nothing more than "window dressing," and, consequently, MSOP's continued detention of over 700 individuals to be unconstitutional.

III. The State's Failure to Timely Transfer Appellants Did Not Meet Contemporary Professional Treatment Standards

A. The State's failure to transfer Appellants to CPS was a denial of treatment

In the civil commitment setting, Minnesota is required to provide "treatment, best adapted, according to contemporary professional standards, to rendering further supervision unnecessary."[25] Where treatment progression is indefinitely delayed, the State has not met its obligation.

MSOP's public facing resources describe transition into a community-based supervision and treatment setting as an important phase in the treatment process. The Department of Human Services states, "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

[24] *See Jackson v. Indiana*, 406 U.S. 715 (1972).
[25] Minn. Stat. § 253B.03, subd. 7 (2021).

re-offense (Phase III)."[26] That late-stage programming, also referred to as Phase III, includes a transition to Community Preparation Services ("CPS") when transfer outside the secure perimeter is approved by the courts. Minnesota Department of Human Services describes treatment progression after transfer to CPS as a "transitional period . . . designed to provide opportunities for clients to apply their acquired skills and to master increasing liberties and responsibility while maintaining public safety."[27]

Despite these polished descriptions, MSOP's structure does not readily facilitate client transition to the Program's final phase of treatment.[28] Instead, the burden is often on MSOP clients themselves to petition for transfer to CPS.[29] A review of the available public data shows that those petitions remain open for an average of 625 days before a final CAP order is issued.[30] In other words, simply following the procedure to get from a

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[26] Minn. Dep't of Hum. Servs., *Minnesota Sex Offender Treatment Program Overview* 1, https://mn.gov/dhs/assets/msop-treatment-overview_tcm1053-313402.pdf (last visited Dec. 13, 2021).
[27] *Id.* at 3.
[28] *See* Minn. Office of Ombudsman for Mental Health and Developmental Disabilities, *Sex Offenders Commitment Process Fact Sheet*, https://mn.gov/omhdd/assets/Sex-Offenders-Commitment-Process-Fact-Sheet_tcm23-473334.pdf (last updated Mar. 2021); *see also* Grant Duwe, *To What Extent Does Civil Commitment Reduce Sexual Recidivism? Estimating the Selective Incapacitation Effects in Minnesota*, 42 J. CRIM. JUST. 2, 193–202 (2014).
[29] *Id.*
[30] A chart entitled *Summary of Cases Appealed to the Commitment Appeal Panel From January 2018 to November 2021* is provided in the Addendum to this Brief at p.12. That chart compiles publicly accessible data regarding time elapsed between SRB Petition and CAP Order and was prepared by Lindsay Dreyer, *Prospective J.D., Mitchell Hamline School of Law class of 2022*, in her capacity as Research Assistant for Eric S. Janus. The chart includes all cases appealed to the Commitment Appeal Panel from January 2018 to November 2021 and publicly available on the Minnesota Appellate Courts Case Management System, at https://macsnc.courts.state.mn.us/ctrack/search/publicCaseSearch.do. Only cases where

petition for transfer or discharge to a CAP order often takes years. This timeline is in sharp contrast to the State's prior representations to this Court about the anticipated duration of MSOP treatment. *See Linehan III*, 557 N.W.2d 171, 188 (Minn. 1996) *cert. granted, judgment vacated sub nom. Linehan v. Minnesota*, 522 U.S. 1011 (1997) (describing the anticipated duration of MSOP as a "four-phase treatment program" with "each of the four phases [] last[ing] approximately 8 months for model patients").

For the Appellants in this case – after years of treatment and lengthy petition processes[31] – both McDeid and Garry received CAP Orders directing their transfer to CPS for the treatment necessary to move toward program completion. Yet, even after receiving judicial orders for transfer, the State failed to take appropriate action to allow Appellants to continue treatment progression. These were not minor delays. After McDeid's CAP Order became effective, the State failed to transfer McDeid for 796 days. Garry's transfer took even longer, with the State failing to transfer Garry for 902 days. In fact, the State took no action to transfer McDeid or Garry until Appellants filed lawsuits.

Disconcertingly, such delays are not uncommon. Earlier this month, on December 2, 2021, the Commitment Appeal Panel held the Commissioner in contempt for failing to transfer an MSOP client to CPS after a CAP order granting his petition for transfer.[32] In

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the SRB petition date was publicly available were included in the average calculation. The 625-day average also excludes currently open cases, cases that were voluntarily dismissed, and cases where the petitioner requested a continuance.

[31] McDeid was originally committed to MSOP in 1999. Garry was committed in 2012.

[32] *See Folson, supra note 23.*

CAP's findings of contempt, CAP notes that "55+" MSOP clients have had their treatment similarly delayed by a failure to transfer for two years or more.[33]

The State's failure to transfer MSOP clients to CPS once their petitions for transfer have been granted is a denial of treatment which actively prevents clients from proceeding from Phase II treatment into Phase III. As detailed above, the State's denial of treatment and failure to provide tangible procedural protections renders their continued detention unconstitutional.

B. The State's conduct is incompatible with contemporary treatment standards

A growing body of research indicates that certain types of treatment interventions for those who have sexually offended can successfully reduce recidivism.[34] That same research shows that treatment programs which fail to follow contemporary evidence-based treatment standards can, at best, be ineffective, and, at worst, increase recidivism.[35] By indefinitely delaying Appellants' transfer to CPS, the State failed to meet contemporary evidence-based treatment standards, undermining the State's claimed goal of providing treatment to increase public safety and facilitate timely societal re-entry.

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[33] *Id.*

[34] Ass'n for the Treatment of Sexual Abusers (ATSA), *Civil Commitment: One Approach for the Management of Individuals Who Have Sexually Abused* 6 (2020), https://www.atsa.com/policy/CivilCommitmentApproach%20forManagement.pdf [hereinafter ATSA, *One Approach for Management*] ("Research indicates that interventions for general offenders that adhere to the [Risk-Need-Responsivity] principles are associated with significant reductions in recidivism, whereas interventions that fail to follow the [Risk-Need-Responsivity] principles yield minimal reductions in recidivism and, in some cases, even result in increased recidivism.").

[35] *Id.*

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")[36] and the Sex Offender Civil Commitment Programs Network ("SOCCPN").[37] According to ATSA and SOCCPN, treatment programs in inpatient civil commitment settings should be grounded in Risk-Need-Responsivity ("RNR") principles.[38] Research shows that treatment programs tailored to follow RNR principles of offender rehabilitation are associated with lower rates of sexual recidivism when compared to offenders who participated in programs following other models and those who did not participate in a treatment program at all.[39]

ATSA summarizes the RNR principles as follows:

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[36] 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.

[37] "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).

[38] *See* ATSA, *One Approach for Management, supra* note 34, at 6; 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).

[39] ATSA & Sex Offender Civil Commitment Programs Network (SOCCPN), *Civil Commitment: If It Is Used, It Should Be Only One Element of a Comprehensive Approach for the Management of Individuals Who Have Sexually Abused* (2015), http://healthdocbox.com/Psychology_and_Psychiatry/91383782-Civil-commitment-if-it-is-used-it-should-be-only-one-element-of-a-comprehensive-approach-for-the-management-of-individuals-who-have-sexually-abused.html; ATSA, *One Approach for Management, supra* note 34, at 1, 5–7.

> [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, so as to maximize their treatment response.[40]

In conjunction with RNR principles, ATSA's practice guidelines state that treatment programs must, among other things, 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."[41]

MSOP's failure to transfer Appellants to CPS after a CAP order directed their transfer violates nearly all of these critical treatment principles. In directing transfer to a less secure environment, CAP concluded that Appellants' risk levels were appropriately low for such a transition and that their treatment objectives would be best served in a less

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[40] ATSA, *One Approach for Management*, *supra* note 34, at 5–6.
[41] 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.* at 1.

restrictive environment. By retaining Appellants in a high security facility and treating them as high-risk clients after their petition process indicated otherwise, MSOP violates ATSA and SOCCPN's "risk" principle. Similarly, in disregarding CAP's individualized assessment, MSOP breaks from the "need" and "responsivity" principles by failing to provide treatment interventions tailored to the needs of each client.

MSOP's treatment program falls even further behind contemporary treatment standards by failing to provide a mechanism for swift transition to less restrictive alternatives, and ultimately, discharge. In fact, MSOP has been repeatedly criticized for a failure to establish clear expectations for moving through the treatment program. *See Karsjens v. Jesson*, 109 F. Supp. 3d 1139, 1156–57 (D. Minn. 2015), *rev'd and remanded sub nom. Karsjens v. Piper*, 845 F.3d 394 (8th Cir. 2017) (noting that "[t]he lack of clear guidelines for treatment completion or projected time lines for phase progression impedes a committed individual's motivation to participate in treatment for purposes of reintegration into the community" and that committed individuals "consistently expressed concerns that slow movement through the program . . . was demoralizing, increased hopelessness, and negatively impacted motivation and engagement"); *see also* Office of the Legis. Auditor, *Civil Commitment of Sex Offenders* 71 (Mar. 2011) (finding that "[a] lack of client motivation has been a barrier to progression in treatment at the MSOP").

Despite criticism of MSOP's failure to provide a path to re-entry as early as 2011, the State's conduct in this case shows what little progress has been made. In practice, the State's failure to follow court orders directing transfer to CPS undermines any client expectations that they will ever be released from confinement, no matter how carefully

and earnestly they adhere to MSOP's "treatment" program. Additionally, by failing to meet the client's treatment needs for an extended period of time, any progress the client has made toward meaningful behavior change, is likely lost and replaced by frustration, anger, and distrust. Such failures generalize across the MSOP population leading to decreased engagement, trust, and motivation, thus reducing the efficacy of MSOP treatment and keeping the Program from achieving its stated treatment goals and its impact on public safety.

IV. Confinement that Fails to Meet Professional Treatment Standards Undermines Public Safety and Increases Costs

As a final note, MSOP represents a massive investment of the State's available resources to combat sex abuse and violence. Despite references to a lack of funding, the State's conduct in preventing treatment and delaying client transfer to CPS only serves to increase costs and undermine Minnesota's goal of public safety.

For fiscal year 2022, Minnesota Department of Human Services reports the cost of MSOP per client per day to be $414, or $151,110 annually,[42] an operating cost far higher than community-based interventions, halfway houses, and even incarceration.[43] With 740 individuals currently in MSOP, that comes to a daily total of approximately

[42] *Sex Offender Treatment: Frequently Asked Questions*, Minn. Dep't of Hum. Servs., https://mn.gov/dhs/people-we-serve/adults/services/sex-offender-treatment/faqs.jsp [hereinafter *Frequently Asked Questions*].
[43] *See Karsjens v. Jesson*, 109 F. Supp. 3d 1139, 1151 (D. Minn. 2015), *rev'd and remanded sub nom. Karsjens v. Piper*, 845 F.3d 394 (8th Cir. 2017); *see also* Office of the Legis. Auditor, *Civil Commitment of Sex Offenders* 2 (Mar. 2011), https://www.auditor.leg.state.mn.us/ped/pedrep/ccso.pdf.

$306,360, and an annual cost close to $100 million dollars.[44] Given MSOP's outlier per capita population and dismal community re-entry statistics, that cost is likely to increase in the coming years. By contrast, halfway houses, similar to CPS, have significantly lower per capita annual costs than secure facilities.[45]

In this case, the State's failure to transfer Appellants McDeid and Garry from a secure treatment facility to CPS for 796 days and 902 days respectively, not only undermined their treatment progress and public safety goals, but also wasted Minnesota's limited resources to combat sexual violence. Using the most recent cost estimates from the Minnesota Department of Human Services, Appellants' delay in treatment likely cost Minnesota over $700,000.[46] Of course, that figure doesn't take into account the systemic nature of MSOP's delays. The Commitment Appeal Panel's recent order holding the Commissioner in contempt, recognized that over fifty-five MSOP clients have had their treatment delayed by the State's failure to obey transfer orders for two years or more.[47] Figuring conservatively, the cost of a two-year delay in treatment for fifty-five individuals at $414 per person per day comes to over $16 million. Of course, this estimate does not take into consideration the substantial delays in receiving a CAP order

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[44] *Frequently Asked Questions*, *supra* note 42.
[45] For example, the 2011 Report of the Office of the Legislative Auditor for the State of Minnesota, found that while MSOP's annual cost per offender at the time was $120,000 per year, the civil commitment program in Texas which housed its committed offenders in halfway houses and provided outpatient treatment had an annual cost of only $27,000 per offender. Office of the Legis. Auditor, *supra* note 43, at 2.
[46] Adding together Appellants' respective delays in treatment (796 days + 902 days = 1,696 days), multiplied by the daily cost of treatment per individual ($414), comes to $702,972. *See Frequently Asked Questions*, *supra* note 42.
[47] *Folson*, *supra note 23* at ¶ 8.

in the first place.[48] In other words, in the last few years, MSOP has spent well over $16 million funding systemic delays nearly identical to the ones at issue in this case. These delays come at great expense, reducing treatment efficacy and public safety while simultaneously depleting Minnesota's resources to prevent sex abuse and violence.

CONCLUSION

The State's conduct in delaying client transfer to CPS has undermined the constitutional legitimacy of MSOP, endangered the State's articulated treatment objectives and public safety goals, and squandered Minnesota's resources. Further, it is simply not plausible that the State and its actors were unaware of their obligations to (1) provide treatment meeting contemporary professional standards and (2) promptly transfer clients to less-restrictive settings when risk and treatment objectives no longer require a high-security environment. The State and its actors should be held responsible for their knowing and systematic failure to obey unambiguous court orders implementing these obligations. For all the above reasons, Amici respectfully ask the Court to reject Respondents' qualified immunity defense, reverse the holding of the Court of Appeals, and remand this case for discovery.

[48] *See Summary of Cases Appealed to the Commitment Appeal Panel From January 2018 to November 2021* included in the Addendum to this Brief, *supra* note 30.

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Respectfully submitted,

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CERTIFICATION OF LENGTH OF DOCUMENT

I hereby certify that the foregoing Brief complies with Minn. R. Civ. App. P. 132.01, subd. 3(c) because it contains 5,699 words, as determined through the word count feature of the Microsoft Word 2016 processing software used to prepare the brief. This brief complies with the typeface requirements of Min. R. Civ. App. P. 132.01, subd. 1 because it has been prepared in a proportionally spaced typeface in 13-point Times New Roman.

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