2009
Annual Report on the Implementation of Mental Hygiene Law Article 10

Sex Offender Management and Treatment Act of 2007

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New York State
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Office of Mental Health

Executive Summary

This is the third annual report to the Governor and Legislature on the implementation of the Mental Hygiene Law (MHL) Article 10: The Sex Offender Management and Treatment Act (SOMTA). Specifically, MHL § 10.10(i) requires the Commissioner for the NYS Office of Mental Health (OMH) to submit to the Governor and Legislature a report on the implementation of this article and that:

> *"Such report shall include, but not be limited to, the census of each existing treatment facility, the number of persons reviewed by the case review teams for proceedings under this article, the number of persons committed pursuant to this article, their crimes of conviction, and projected future capacity needs."*

This report provides an overview of SOMTA and presents data on related assessment, litigation and treatment issues. During the 12-month reporting period from November 1, 2008 through October 31, 2009, OMH reviewed 1,722 sex offenders with SOMTA-qualifying offenses and recommended 63 for civil management.

OMH operates two secure treatment facilities—a 150-bed secure treatment facility located within the Central New York Psychiatric Center and an 80 bed secure treatment facility located in the grounds of St. Lawrence Psychiatric Center. These two facilities, along with a temporary secure treatment unit within the Manhattan Psychiatric Center located on Ward's Island in New York City, have the capacity to provide secure treatment to 250 sex offenders. As of October 31, 2009, 200 offenders were designated to a secure treatment facility. In addition, 46 were in the community under a Strict and Intensive Supervision and Treatment (SIST) order and another 13 were incarcerated awaiting disposition of an alleged SIST or parole violation.

Rates of rearrest among referrals that were not recommended for civil management remain low. Overall, roughly 1.6% of those offenders were re-arrested for a sexual offense within a year of their release to the community, while 2.9% were re-arrested at the two-year mark.

OMH continues to develop and enhance treatment services at its secure treatment programs. During this reporting period, OMH expanded its use of the penile plethysmograph (PPG) assessment process and developed and implemented protocols for the use of selective serotonin reuptake inhibitors (SSRI) and anti-androgen therapy (AAT).

Between November 1, 2008 and October 31, 2009, OMH completed 57 annual reviews of civilly confined individuals in secure treatment. In one case, OMH determined that the individual was no longer a dangerous sex offender requiring secure treatment and, upon OMH's recommendation, the court released him to the community under a SIST order. The court also released two other residents despite OMH's finding that they continued to be dangerous sex offenders in need of confinement. Both were released to the community under SIST orders.

Introduction

This report is submitted to Governor Paterson and the Legislature by the Commissioner of OMH pursuant to Article 10 of the MHL. Specifically, MHL § 10.10(i) requires the Commissioner to submit to the Governor and the Legislature a report on the implementation of this article and that,

> *"Such report shall include, but not be limited to, the census of each existing treatment facility, the number of persons reviewed by the case review teams for proceedings under this article, the number of persons committed pursuant to this article, their crimes of conviction, and projected future capacity needs."*

The following pages serve to review the history and implementation of MHL Article 10, which was enacted as part of SOMTA. Part I of this report provides an overview of the legislative intent of SOMTA and the purpose of civil management. Part II describes the assessment of sex offenders by OMH upon their admission to prison. Part III of the report summarizes the assessment process employed by OMH to identify sex offenders in need of civil management. Part IV reviews the adjudication of Article 10 cases, while Part V presents information on the treatment of individuals involved in civil management.

Part I: The Sex Offender Management and Treatment Act

SOMTA was enacted as Chapter 7 of the Laws of 2007, and became effective April 13, 2007. The legislation amended sections of New York State's Correction, County, Criminal Procedure, Executive, Judiciary, Penal, and Mental Hygiene Laws, and the Family Court Act, and created an elaborate process for the civil management of certain sex offenders upon completion of their prison terms. SOMTA also requires a risk assessment of sex offenders by qualified staff upon their admission to prison, as well as prison-based sex offender treatment, to be provided by DOCS, including residential treatment.

The assumptions underlying SOMTA were delineated in a series of Legislative Findings set forth in the MHL §10.01. Specifically, the Legislature found that:

- Recidivistic sex offenders who pose a danger to society should be addressed through comprehensive and integrated programs of treatment and management. {§ 10.01(a)}
- Some offenders with mental abnormalities are predisposed to engage in repeated sex offenses. These offenders may require long-term specialized treatment modalities to address their risk of re-offense. That treatment should continue following incarceration. In extreme cases, confinement will need to be extended by civil process in order to ensure treatment and protect the public. {§10.01(b)}
- For other sex offenders, it can be effective and appropriate to provide treatment in a regimen of strict and intensive outpatient supervision. Civil commitment should be only one element in a range of responses. {§ 10.01(c)}
- The system for responding to recidivistic sex offenders with civil measures must be designed for treatment and protection. It should be based on the most accurate scientific understanding available, including the use of current, validated risk assessment instruments. {§10.01(e)}
- The system should offer meaningful forms of treatment to sex offenders in all phases of criminal and civil supervision. {§ 10.01(f)}
- Sex offenders in need of civil commitment comprise a different population with different needs from traditional mental health patients. The civil commitment of sex offenders should be implemented in ways that do not endanger, stigmatize, or divert needed treatment resources away from traditional mental health patients. {§ 10.01(g)}

While the U.S. Supreme Court has determined that civil commitment for the purpose of incapacitation and treatment (rather than punishment) is constitutional, it has placed limitations on government's authority to civilly commit sex offenders. Government does not have the authority to civilly commit a sex offender simply because he or she is dangerous and has committed multiple offenses. Rather, civil commitment is authorized only in very limited

circumstances in which the sexual offending stems from a mental abnormality which results in serious difficulty in controlling behavior.[1] To the extent that other dangerous, repetitive sex offenders require long-term incapacitation, it is incumbent upon the criminal justice system to insure that outcome through appropriate terms of incarceration.

SOMTA, through the creation of Article 10, established an elaborate process to review certain sex offenders in the custody of "Agencies with Jurisdiction" for purposes of civil management.[2] Article 10 requires OMH to evaluate and recommend individuals for civil management and provide treatment to individuals found by the court to be in need of civil management. More specifically, the statute provides for the Commissioner of Mental Health to employ multidisciplinary staff, case review teams, and psychiatric examiners to identify persons suffering from a mental abnormality that predisposes them to sexual recidivism and may require civil management.[3] It also requires OMH to develop treatment plans for persons released to the community under "Strict and Intensive Supervision and Treatment" (SIST) and to establish secure treatment facilities for persons deemed in need of confinement.

Part II: Assessment of Offenders at Intake to DOCS Custody

Under Correction Law Section 622, as enacted by SOMTA, sex offenders committed to the custody of the NYS Department of Correctional Services (DOCS) are to be initially assessed by OMH staff knowledgeable regarding the diagnosis, treatment, assessment or evaluation of sex offenders. The assessment includes, but is not limited to, a determination of the offender's risk of sexual recidivism and his or her need for sex offender treatment while in prison. The assessment results are shared with DOCS for appropriate treatment program placement. In order to comply with these requirements, an evaluation unit was established in 2007 at the Downstate Correctional Facility, which accounts for approximately 50% of all sex offenders committed to the custody of DOCS. The OMH Sex Offender Evaluation Unit (SOEU) at Downstate Correctional Facility is currently evaluating all inmates with sexual offenses or sexually motivated felonies that are committed through that facility. More recently, OMH evaluations were extended to cover admissions from Elmira Reception Center. Evaluations of admissions through Elmira are completed by OMH staff in the Bureau of Sex Offender Evaluation and Treatment (BSOET) at OMH Central Office.

Procedures at Downstate Reception Center:

Each day, Downstate Correctional Facility receives a "draft" of incoming inmates from county jails in the eastern half of the State. To accomplish risk screens on all incoming inmates, every morning the SOEU reviews each inmate in the draft to identify those with SOMTA-qualifying offenses or designated felonies that appear to be sexually motivated. This review identifies an average of two to three inmates per day with qualifying offenses. SOEU staff generates rap sheets from the e-Justice and the National Crime Information Center (NCIC) systems, obtains the pre-sentence investigation report (PSR) for the instant offense from DOCS, and gathers additional data on the identified cases via searches of the DOCS and OMH databases. If needed, staff also contacts the Office of the District Attorney involved in the case to clarify risk-relevant aspects of the crime (e.g., relationship to victim), gathers prior disciplinary tickets for sexual behavior in prison, and orders records from prior DOCS sex offender treatment, if applicable. Each afternoon, the above-delineated information is disbursed to SOEU licensed psychologists who complete an actuarial assessment of risk and, if indicated, conduct additional testing and prepare a comprehensive report outlining dynamic risk factors, treatment needs and recommendations.

1 Kansas v. Crane, 534 U.S. 407 (2002).

2 MHL § 10.01(a) defines an Agency with Jurisdiction as "the agency responsible for supervising or releasing such person (sex offender) and can include the Department of Correctional Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities and the Division of Parole."

3 The definition of mental abnormality under New York's statute is virtually identical to that of other states with SVP statutes. MHL Article 10 defines mental abnormality as a "congenital or acquired condition, disease or disorder that affects the emotional, cognitive, or volitional capacity of a person in a manner that predisposes him or her to the commission of conduct constituting a sex offense and that results in that person having serious difficulty in controlling such conduct." Persons referred for assessment for civil management include (1) sex offenders with qualifying offenses in the custody of DOCS who are approaching release, (2) persons under supervision of the NYS Division of Parole who are approaching the end of their terms of supervision, (3) persons found not responsible for criminal conduct due to mental disease or defect and who are due to be released, (4) persons found incompetent to stand trial and who are about to be released, and (5) persons convicted of sexual offenses who are in a hospital operated by OMH and were admitted per the Executive Directive (Harkavy cases).

Procedures at Elmira Reception Center:

Sex offenders adjudicated in the western part of the State are processed through the Elmira Correctional Facility. To accomplish risk screens on all incoming sex offenders entered through Elmira, a clerk from Elmira Correctional Facility's admissions office identifies offenders with SOMTA qualifying offenses or designated felonies that appear to be sexually motivated and sends a daily list to OMH BSOET located at OMH Central Office in Albany. On average, one to two inmates per day are referred to OMH.

For each offender identified with a SOMTA-qualifying offense, BSOET staff generates a rap sheet from e-Justice and NCIC, requests a PSR for the instant offense from DOCS, and requests records regarding the instant offense from the Office of the District Attorney who prosecuted the case. As with SOEU staff, BSOET staff also may seek prior PSRs from DOCS if the offender has served a prior prison term for a sexual offense as well as prior incarceration disciplinary tickets for sexual offenses, and prior DOCS sex offender treatment records. These cases are then assigned to clinicians in the Risk Assessment and Record Review (RARR) unit within OMH BSOET who complete an actuarial risk assessment, results of which are shared with the DOCS Counseling and Guidance unit on a weekly basis. If indicated, RARR clinicians also prepare a written report outlining dynamic risk factors and treatment needs and recommendations.

Of the cases screened during the reporting period of November 1, 2008 to October 31, 2009, 42% involved an enhanced evaluation that included a detailed examination of dynamic risk factors and treatment needs.

Part III: Assessment of Sex Offenders for Civil Management

OHM has established a Risk Assessment and Record Review (RARR) unit to evaluate all offenders convicted of qualifying offenses who are referred for assessment under Article 10 (see Table A-1 in appendix for a list of all qualifying offenses). Each assessment involves the review of multiple records including, but not limited to, police reports, victim statements, court transcripts, pre-sentence reports, and correctional and mental health records. The goal of the assessment process is to identify and refer sex offenders who suffer from a mental abnormality and pose a high risk for sexual recidivism as defined in the statute.

The first step in the review process is to ensure that the referred individual has been convicted of a qualifying offense. Once a qualifying offense has been confirmed, the next step is to determine whether or not the referred individual has a sexual offense history that involves more than one victim. While the absence of multiple victims does not preclude a case from moving forward for civil management, single-victim cases are only moved forward when the case involves indications of murder, torture, sexual sadism, or statements of intent to re-offend.[4] The presence of multiple victims is relevant to establishing volitional impairment resulting in the individual having serious difficulty controlling his or her behavior.[5]

Actuarial Assessments

Once it has been determined that the qualifying offense and multiple victim criteria have been met, decisions regarding further review are guided, though not exclusively determined, by the individual's score on an actuarial risk assessment known as the Static-99. This highly researched and validated actuarial risk assessment tool is designed to assist in the prediction of sexual recidivism (defined as a new criminal charge or conviction) among male sex offenders. The instrument includes measurements of criminal history, age at the time of scheduled release, prior cohabitation with intimate partner(s), victim gender, and victim-offender relationship. Based on research

4 A single victim case is defined as a case where there is evidence of only one sexual offense victim in the record. If any record reveals multiple victims of contact and/or non-contact sexual offenses, the case is identified as having more than one victim. In addition, if a case involves an individual who sexually offended against a single victim and then after being sanctioned for that offense, committed another sexual offense against the same victim, the case is viewed as having more than one victim.

5 While single-victim cases involving murder, torture, or sexual sadism can be forwarded for CRT review, the purpose of doing so is to closely review the individual's history to identify factors that suggest a pattern of behavior, i.e., multiple victims or intent to reoffend.

within and outside the U.S., the Static-99 classifies sex offenders into one of 10 levels of risk based on their history. Each Static-99 risk level has a particular expected rate of sexual recidivism. OMH staff has been trained in the use of this actuarial instrument by certified trainers to ensure proper implementation.

In April 2009, the RARR unit implemented a second risk assessment instrument known as the Screening Scale for Pedophilic Interests (SSPI).[6] The SSPI provides OMH staff a standardized way to measure the extent of sexual interest an offender may have toward children. It is used for any male sex offender who has at least one child victim age 13 or younger. The presence of pedophilic interest is a significant research-based risk factor for sexual recidivism. That is, research studies have shown the SSPI score to be positively correlated with sexual recidivism.[7] Moreover, results of the SSPI have been shown to correlate with those of other measures of pedophilic interest such as the penile plethysmograph (PPG).[8]

Multidisciplinary Review Team and Case Review Team Assessments

Two separate clinical teams are utilized in the civil management review process. The Multidisciplinary Review (MDR) team, comprised of three randomly selected clinicians with extensive training and expertise in sex offender assessment, completes initial reviews of cases by examining risk and protective factors, diagnosis, treatment, and/or management of sex offenders. Through this initial assessment, the MDR team determines whether or not the case should be referred to the Case Review Team (CRT) for a more comprehensive and in-depth evaluation.

Sex offenders who meet the risk thresholds established for the MDR team enter a second level of review conducted by the CRT. Like the MDR team, the CRT also is comprised of three staff (two of whom were not part of the MDR team) with expertise in the assessment of sex offenders. The CRT undertakes an in-depth review of the causes and patterns of the individual's sexual offending, his or her criminal, mental health, and substance abuse history, and related problem behaviors while incarcerated and during periods of supervision. If the initial CRT review indicates that civil management may be warranted, the CRT requests that a psychiatric examiner evaluate the respondent for the presence of a mental abnormality, as defined by statute.

When the CRT requests a psychiatric examination a licensed psychologist conducts a detailed psychological examination to assess for mental abnormality, using methods approved by clinical and professional practice groups.[9] The findings from this evaluation are incorporated into a report which is presented to the CRT for final determination as to whether or not the individual is in need of civil management. Based upon information obtained from the psychiatric evaluation, as well as the comprehensive record review, the CRT makes a determination whether or not to refer the individual to the New York State Office of the Attorney General (OAG) to seek civil management. OMH then issues a Notice of Determination to the relevant parties (e.g., referring agency, OAG, referred individual) noting its finding on the issues of mental abnormality, likelihood to re-offend, and the need for civil management. The decision to refer for civil management must be unanimous among CRT members. The CRT does not make recommendations as to whether the individual is a dangerous sex offender in need of civil confinement or a sex offender in need of SIST. The dangerousness determination is made by the court, subsequent to the finding of mental abnormality based upon the report and the testimony of the psychiatric examiner. The psychiatric examiner may speak to the risk levels warranting confinement or a SIST determination.[10]

6 Seto, Michael C., & Lalumiere, Martin L. (2001) A Brief Screening Scale to Identify Pedophilic Interests Among Child Molesters. Sexual Abuse: A Journal of Research and Treatment, 13(1), 15-25.

7 Seto, M. C., Harris, G. T., Rice, M. E., & Barbaree, H. E. (Oct. 2004) The Screening Scale for Pedophilic Interests Predicts Recidivism Among Adult Sex Offenders With Child Victims. Archives of Sexual Behavior, 33(5), 455-466.

8 Ibid.

9 Clinicians follow protocols and practices recommended by the American Psychological Association and the Association for the Treatment of Sexual Abusers.

10 Sex offenders requiring civil management include "dangerous sex offenders requiring confinement" and those appropriate for "strict and intensive supervision and treatment" (SIST). A "dangerous sex offender requiring confinement" means a person who is a detained sex offender suffering from a mental abnormality involving such a strong predisposition to commit sex offenses, and such an inability to control behavior, that the person is likely to be a danger to others and to commit sex offenses if not confined to a secure treatment facility. A sex offender requiring SIST means a detained sex offender who suffers from a mental abnormality, but is not a dangerous sex offender requiring confinement.

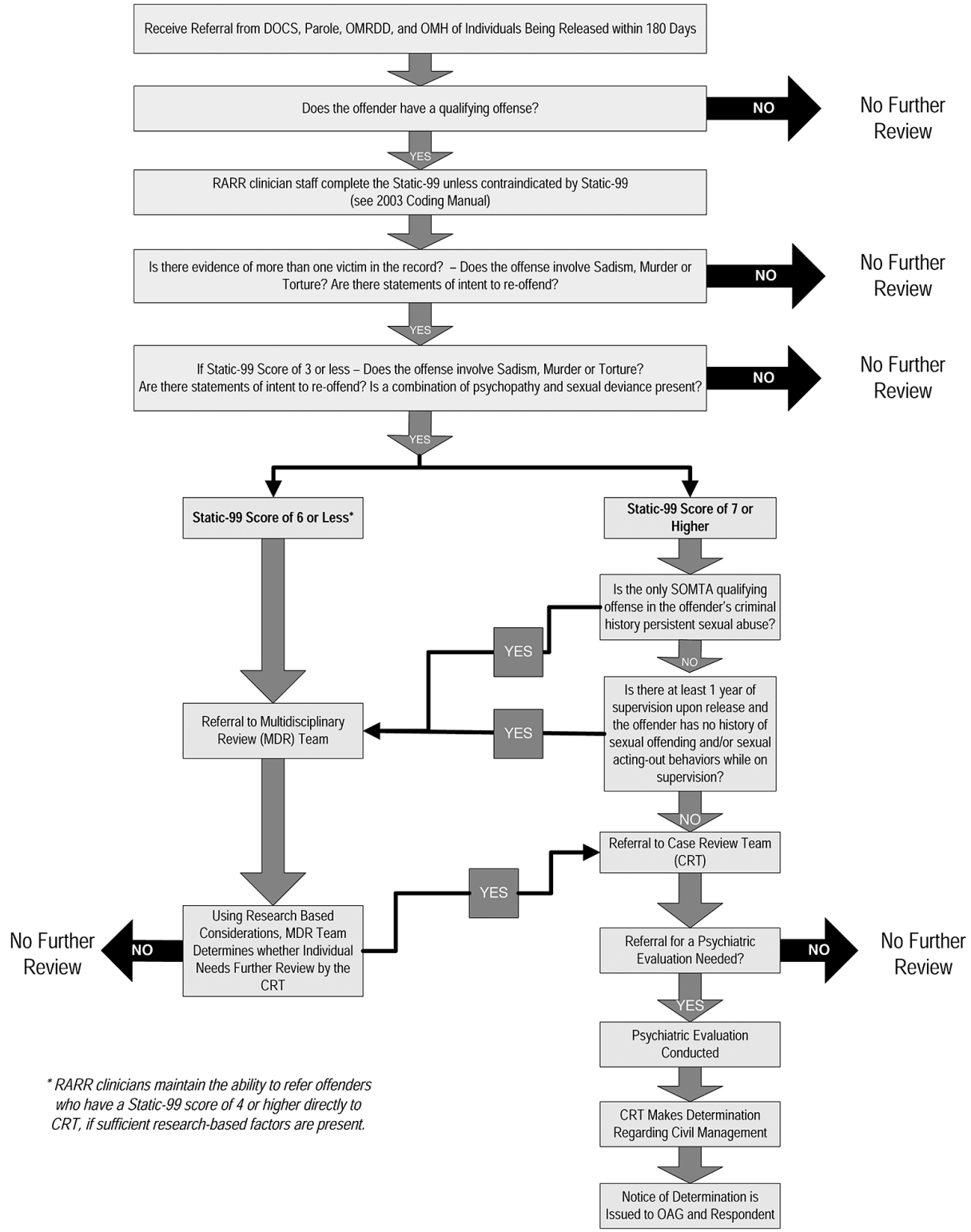
The Static-99 score is the initial determiner of the path the case will take through the review process. Prior to 2009, OMH targeted those scoring "6" or higher to by-pass screening by the MDR team and move directly to a more intensive review by the CRT. A threshold of "6" was selected based on the research with the belief that individuals at that level of risk had an expected rate of sexual recidivism of approximately 40% over a 10-year follow-up period. In late 2008, however, the developers of the Static-99 revised the expected rates of sexual recidivism based upon more recent studies of sexual recidivism across all risk levels. The more recent studies indicated that the expected rates of recidivism for today's offenders are lower (at each level of the Static-99) than what occurred 10 years ago when the Static-99 was first developed and normed (the original norms were based on groups of offenders released from prison during the 1970s and early 1980s). In fact, the 40% 10-year recidivism rate was found to be more akin to today's Static-99 level 7. Based upon this finding and in consultation with Dr. R. Karl Hanson, developer of the Static-99, the guidepost for immediate, intensive screening by the CRT was adjusted in early 2009 from a level "6" to a level "7."

Offenders scoring a "7" or higher on the Static-99 would by-pass screening by the MDR team and move immediately to the CRT screening unless: 1) the offender had at least one year of parole supervision remaining on his term and had not, in the past, exhibited improper sexual behavior while under probation or parole supervision, or; 2) the offender's records indicate nothing more serious than a low-level felony offense (e.g., "persistant sexual abuse") involving repeated misdemeanor level "forcible touching" or repeated misdemeanor level "sexual contact." In such cases, these offenders would be first screened by the MDR team and a determination about whether or not to refer the case to the CRT for further review would be made.

The updated recidivism estimates by the developer of the Static 99 and the increased weight OMH review protocols placed on the protective factor of parole supervision did alter the probability that cases with these characteristics would result in a civil management recommendation. In fact, the adjustments to the risk assessment process that were made in early 2009 resulted in a decline in referrals for civil management to OAG from 2008. This decline has occurred largely among cases with significant parole time left on their sentences. Upon completion of that supervision, these offenders can be re-referred to OMH by Parole for consideration for referral to OAG for civil management, in effect providing the opportunity for a second assessment as to the need for civil management.

The OMH RARR process is summarized on the following page in Figure 1.

Figure 1
Risk Assessment and Record Review (RARR) Civil Management Review Process



Results of civil management screening by OMH

From November 1, 2008 to October 31, 2009, 1,798 cases were reviewed by OMH for possible civil management. Of those, 76 referrals (4.2%) were deemed not to have committed a SOMTA-qualifying offense.[11] Of the 1,722 referrals qualifying for review, 1,598 (92.8%) were referred from the Department of Correctional Services (DOCS), 119 (6.9%) were referred from the Division of Parole, and 5 (0.3%) were referred from the Office of Mental Health (OMH) or the Office of Mental Retardation and Developmental Disabilities (OMRDD). The 1,722 referrals involved 1,686 unique offenders, as some offenders were referred and reviewed more than once during the reporting time period.

Of the 1,686 offenders qualifying for review, 194 (11.5%) were referred for further review by the CRT, of which 63 (3.7%) were recommended for civil management. Characteristics of the offenders' criminal histories, SOMTA-qualifying offenses, and sexual recidivism risk scores are displayed in Tables 1 and 2. As shown, those offenders referred to the OAG for pursuit of civil management have more extensive sexual offense histories, more frequent incarcerations, higher risk scores, and were less likely to have parole time remaining on their sentences than those not referred for civil management. As noted in Table 2, sex offenders referred to the OAG for civil management averaged 5.8 years in DOCS custody prior to their first release on the sentence underlying their Article 10 referral. Of respondents referred to the OAG during the reporting period, 24% did not have a record of participating in DOCS sex offender treatment, while the remaining 76% averaged 6.9 months in DOCS sex offender treatment prior to their release.

From April 13, 2007 to October 31, 2009, 185 decisions regarding civil management have been handed down by the courts. Mental abnormality was found in 171 (92.4%) of the trials, 99 of which resulted in a finding that the respondent is a dangerous sex offender requiring confinement and 72 resulted in SIST determinations.[12]

The current rate of referral for civil management (3.7%) is similar to those of other states with similar referral processes. For example, in California and Florida, the two largest states with similar review processes (whereby all prison releases are screened for civil management) 2.3% (California) and 1% (Florida) of all referrals result in confinement. Likewise, in Washington and Minnesota (other states with a similar referral and review processes), the commitment rates are 1.3% and 1.5%, respectively.

11 Between November 1, 2008 and October 31, 2009, the RARR unit reviewed 1,686 offenders for civil management consideration. The RARR unit, however, completed 1,798 reviews (i.e., some offenders had multiple reviews) during this same time period.

12 Probable cause was not found in two of the 185 cases. Additionally, the court found in favor of the respondent in 12 of the cases.

Table 1
Characteristics of Offenders Reviewed Under SOMTA

Characteristics of Referrals [1]	No CRT (n = 1450)	CRT, No CM (n = 131)	CM (n = 63)
Static 99 Risk Score			
Percent 0-3	74.9%	10.0%	1.6%
Percent 4-5	22.2%	31.3%	19.1%
Percent 6-7	2.7%	54.2%	54.0%
Percent 8 or higher	0.1%	4.6%	25.4%
Average score (Standard Deviation - SD)	3.0 (2.0)	6.0 (2.0)	7.0 (1.0)
Victim/Offender Relationship [2]			
Percent unrelated	72.9%	97.7%	98.4%
Percent stranger	16.6%	51.1%	66.7%
Characteristics of Victims in History			
Percent male victim	13.9%	27.5%	46.0%
Percent with "child victim" charge in criminal history [3]	73.1%	58.9%	63.5%
SSPI Score [4]	(n = 135)	(n = 32)	(n = 39)
Average score (SD)	2.7 (1.4)	3.4 (1.6)	4.6 (0.8)
Characteristics of Instant Offense	(n = 1492)	(n = 131)	(n = 63)
Percent PL 130 Offense	88.0%	84.7%	85.7%
Rape	38.8%	38.9%	23.8%
Sexual Abuse	26.2%	28.2%	31.7%
Criminal Sexual Act (Sodomy)	18.4%	14.5%	30.2%
Other PL 130	4.6%	3.1%	0.0%
Percent other sexual offense	0.9%	0.8%	1.6%
Percent designated felony [5]	11.1%	14.5%	12.7%
Region of Last Conviction Prior to SOMTA Review [6]	(n = 1485)	(n = 131)	(n = 63)
Percent New York City	28.0%	33.1%	31.8%
Percent suburban New York City	10.6%	7.7%	7.9%
Percent upstate new York	61.4%	59.2%	60.3%
Parole Time Remaining on Sentence	(n = 1492)	(n = 131)	(n = 63)
Percent with at least 1 year	55.3%	51.5%	38.1%

Notes: No CRT = Case was not referred to CRT review; CRT, No CM = Case was reviewed by CRT, but not recommended for Civil Management; CM = Case was recommended for Civil Management.

1 42 Offenders were not scored with the Static-99; 14 were Adolescent at the time of offense, 22 were Female offenders, and 6 had the Presence of Only a Category B Offense. Also, an additional 36 offenders were referred to OMH for SOMTA review, but were deemed to not have committed a SOMTA-qualifying offense.

2 Victim/Offender Relationship was defined as outlined in the Static-99 coding manual.

3 OMH had the data for all cases

4 SSPI data was available starting April 2009.

5 See Table A-1 for a listing of designated felonies.

6 OMH did not have the Region of Last Conviction for 7 offenders who did not go onto CRT.

Table 2
Criminal Histories of Offenders Reviewed Under SOMTA

Criminal History of Referrals	No CRT (n = 1486) [1]	CRT, No CM (n = 130) [1]	CM (n = 63) [1]
Arrests Prior to SOMTA Review			
Average number (SD)	4.6 (4.9)	7.2 (5.7)	6.4 (4.7)
Percent 2 or more	75.7%	91.5%	93.7%
Felony Arrests Prior to SOMTA Review			
Average number (SD)	2.7 (2.4)	4.0 (3.3)	3.6 (2.2)
Percent 2 or more	59.6%	80.8%	85.7%
Convictions Prior to SOMTA Review			
Average number (SD)	4.0 (4.2)	6.3 (5.2)	5.5 (4.3)
Percent 2 or more	70.5%	86.9%	90.5%
Felony Convictions Prior to SOMTA Review			
Average number (SD)	1.8 (1.3)	2.5(2.0)	2.4 (1.4)
Percent 2 or more	44.9%	64.6%	76.2%
Sexual Arrests Prior to SOMTA Review			
Average number (SD)	1.2 (0.6)	2.0 (1.4)	2.5 (1.5)
Percent 2 or more	19.7%	59.2%	74.6%
Sexual Convictions Prior to SOMTA Review			
Average number (SD)	1.2 (0.6)	1.9 (1.4)	2.4 (1.4)
Percent 2 or more	17.4%	55.4%	76.2%
Prison Sentences Prior to SOMTA Review			
Average number (SD)	1.6 (0.9)	1.8 (1.7)	1.9 (1.1)
Percent 2 or more	26.4%	42.3%	63.5%
Probation Sentences Prior to SOMTA Review			
Average number (SD)	0.6 (0.8)	0.8 (1.0)	0.6 (0.7)
Percent 2 or more	10.6%	21.5%	11.1%
Time Spent in DOCS on SOMTA Offense (excl. jail) [2]			
Average number of years (SD)	4.9 (4.5)	6.1 (5.8)	5.8 (6.5)
Percent 3 years or more	52.5%	57.8%	57.1%

Notes: No CRT = Case was not referred to CRT review; CRT, No CM = Case was reviewed by CRT, but not recommended for Civil Management; CM = Case was recommended for Civil Management.

1 OMH did not have the criminal history of 6 offenders that did not go onto CRT and 1 offender who the CRT ruled no CM. An additional 36 offenders were referred to OMH for SOMTA review, but were deemed to not have committed a SOMTA-qualifying offense.

2 Data were available only for Respondents who were considered a New Commitment by DOCS.

Timeliness of Civil Management Determinations

OMH strives to complete the review process for civil management referrals through issuance of a Notice of Determination at least ten business days prior to an offender's release date. As can be seen in Table 3, on average, OMH makes these determinations 27 business days prior to an offender's release. This represents an increase of over two weeks (16 days) compared to the previous year.

Table 3
Number of Business Days between Respondent Release Date and the Notice of Determination

Month	Average Number of Business Days Between Offender Release Date and the Notice of Determination
November 2008	10
December 2008	20
January 2009	23
February 2009	24
March 2009	25
April 2009	24
May 2009	38
June 2009	40
July 2009	42
August 2009	36
September 2009	15
October 2009	24
Average for the Annual Review Reporting Period	27

Post release arrests of individuals not referred for civil management

Re-arrest data were available on 2,722 offenders evaluated under SOMTA since its inception, deemed not to be in need of civil management, and released from DOCS. An analysis was conducted to determine the rates of re-arrest for these offenders, both any re-arrest and sexual re-arrest, during their time in the community (i.e., post civil management review). Because these individuals varied in terms of their "time at risk" in the community, a statistical technique termed "survival analysis" was employed to measure the extent of recidivism. Survival analysis essentially develops a "best estimate" of recidivism over time for an entire sample given the patterns of recidivism occurring among sub-samples "at risk" for various amounts of time.

Figure 2 provides a "best estimate" of re-arrest (for any offense) for those individuals who were released from DOCS custody subsequent to an OMH decision to not pursue civil management. The blue line represents persons categorized as low risk by the Static-99 (score "0-1"), the yellow line represents those offenders categorized as medium-low risk by the Static-99 (score "2-3"), the black line represents those offenders categorized as medium-high risk by the Static-99 (score "4-5"), and the red line represents persons with a Static-99 score of "6" or higher (high risk). Across all four groups of offenders, approximately 17% were re-arrested within their first year of release, while 28% were re-arrested within their first 2 years of release. The re-arrest rate was highest at the 1-year mark for those offenders scoring "4" or "5" on the Static-99 (re-arrest rate of 25%) and highest at the 2-year mark for those offenders scoring a "6" or higher on the Static-99 (42%). It should be noted that the group of offenders scoring "6" or higher is relatively small and, thus, provides less stable estimates toward the end of the analytic period.

Figure 2
Survival Analysis of Re-Arrest for Any Offense Post Release from DOCS

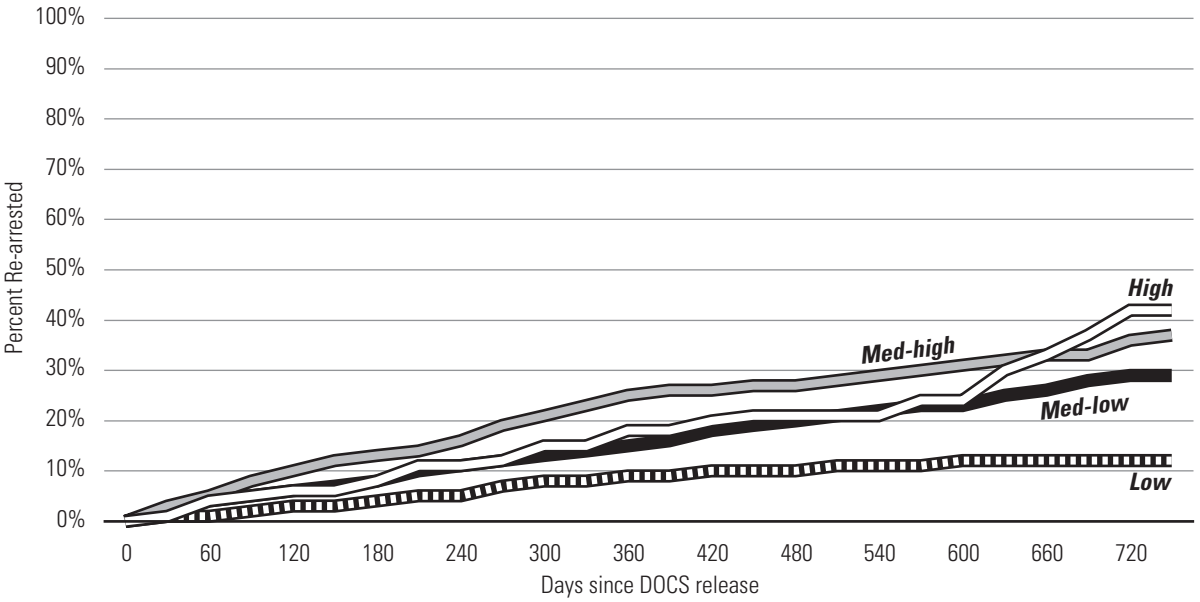
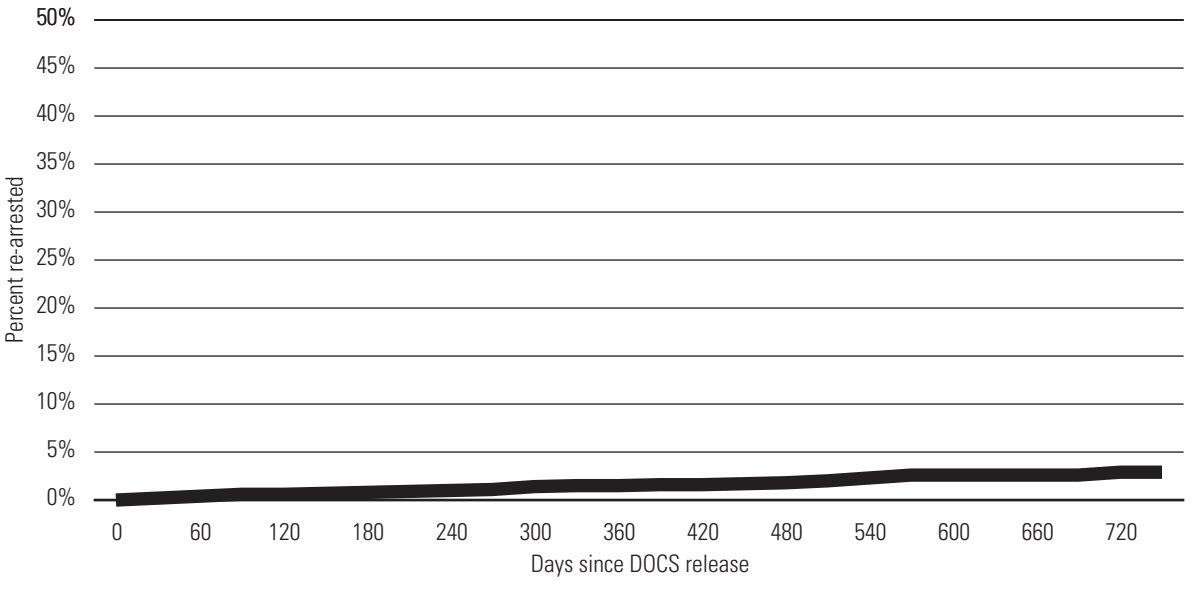


Figure 3 shows the trend in re-arrest for a sexual offense for the entire group of releases. This analysis is not provided by risk level because the rates of re-arrest were so low that estimates for subgroups lacked stability. Overall, roughly 1.6% of the offenders were re-arrested for a sexual offense at the one-year mark, while approximately 2.9% were re-arrested for a sexual offense at the two-year mark. Over 80% of the rearrests involved misdemeanor or low-level (Class E) felony charges. Thus, approximately one half of one percent were rearrested for higher-level felony sex offense. Forcible touching was the most common type of charge. More "time at risk" and larger sample sizes are needed, however, to reliably discern differences in patterns of sexual recidivism across risk groups.

Figure 3
Survival Analysis of Re-Arrest for a Sexual Offense Post Release from DOCS



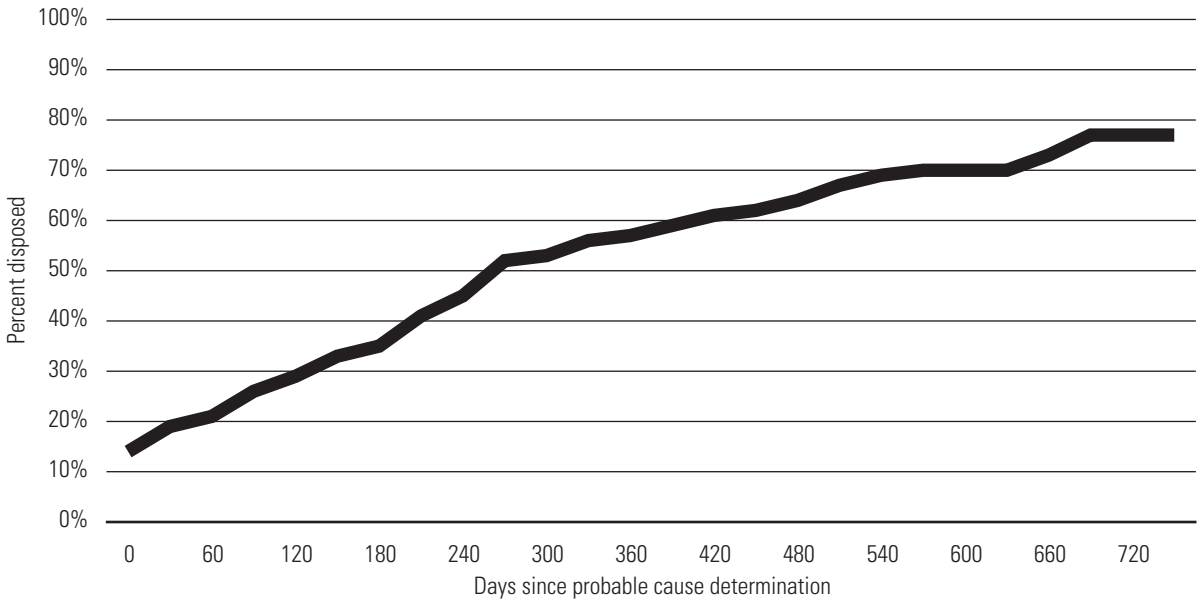
Part IV: The Adjudication of Article 10 Referrals

Between the effective date of Article 10 (April 13, 2007) and October 31, 2009, OMH has referred 356 sex offenders to the OAG for civil management adjudication, 63 of whom were referred during the reporting period November 1, 2008 thru October 31, 2009.[13]

Article 10 provides that within 30 days of the filing of the sex offender civil management petition, the Court shall conduct a hearing to determine whether or not there is probable cause to believe the Respondent is a sex offender with a mental abnormality, as defined by statute. From November 1, 2008 to October 31, 2009, 84 probable cause determinations have occurred. Since inception of SOMTA, all but two hearings resulted in an affirmative finding of probable cause.

The litigation in civil management cases is often protracted, requiring multiple court proceedings and appearances by OMH psychiatric examiners. Figure 4, below, shows the percent of cases reaching disposition by the number of days since probable cause determination. As can be seen, fewer than 60% of the cases were disposed within one year of the probable cause determination.

Figure 4
Survival Analysis of Time to Disposition in Article 10 Cases



13 Sixty of the cases referred prior to November 1, 2008 were "Harkavy cases" that were re-evaluated under Article 10.

Article 10 trial process

Article 10 respondents have the right to a trial by jury. The jury, or court if a jury trial is waived by the respondent, must determine (by unanimous vote) whether a respondent is a "detained sex offender who suffers from a mental abnormality." The burden of proof, placed upon the OAG, is one of "clear and convincing evidence." If the jury, or court if a jury trial is waived, finds that the respondent suffers from a mental abnormality, the trial judge must determine whether the respondent is a dangerous sex offender requiring confinement or a sex offender requiring strict and intensive supervision and treatment (SIST). As with the earlier phase of trial, the standard of proof for the dangerousness determination is one of "clear and convincing evidence."

As of October 31, 2009, 185 decisions regarding civil management have been handed down by the court since SOMTA's enactment in 2007. Mental abnormality was found in 171 of the cases (92.4%), 99 of which resulted in a finding that the respondent is a dangerous sex offender requiring confinement and 72 of which resulted in SIST determinations.

Sex offenders involved in the civil management process receive treatment within an OMH secure treatment facility if they are placed there pending trial or have been adjudicated as a dangerous sex offender requiring confinement. Those adjudicated as sex offenders requiring civil management, but not adjudicated as dangerous sex offenders, are released to the community under a SIST order. As of October 31, 2009, 100 respondents were in secure treatment pre-trial awaiting adjudication, 100 were in secure treatment as dangerous sex offenders requiring confinement, and 46 were under active SIST orders. Three-fifths of those adjudicated as a dangerous sex offender consented to confinement rather than proceeding to trial.

Table 4 shows the criminal histories and Static-99 scores of those respondents who, based on the initial court decision, were placed on SIST or civilly confined in an OMH facility. The SIST placements are grouped by whether OMH recommended the placement. As shown, over one-third of the SIST placements were not recommended by OMH. Moreover, the SIST placements who were not recommended by OMH had more extensive criminal histories than the SIST placements that had been supported by OMH. For example, SIST placements not recommended by OMH averaged 3.3 sexual offense arrests prior to SOMTA review, while those recommended for SIST averaged 2.1 such arrests.

Table 4
Offenders Reviewed Under SOMTA and Placed on SIST or Civilly Confined

Original Decision of SIST or Confinement	Court Order to SIST		Court Order to Confinement
	SIST Recommended by OMH (n = 45)	SIST Not Recommended by OMH (n = 27)	Inpatient (n = 99)
Criminal History of Referrals	(n = 44) [1]	(n = 27)	(n = 96) [1]
Arrests Prior to SOMTA Review			
Average number (SD)	5.8 (4.4)	9.0 (10.2)	7.1 (7.7)
Percent 2 or more	88.6%	96.3%	94.8%
Felony Arrests Prior to SOMTA Review			
Average number (SD)	3.3 (2.1)	4.0 (2.7)	3.5 (2.7)
Percent 2 or more	81.8%	88.9%	79.2%
Convictions Prior to SOMTA Review			
Average number (SD)	5.1 (4.2)	7.9 (10.1)	6.2 (6.8)
Percent 2 or more	84.1%	96.3%	90.6%
Felony Convictions Prior to SOMTA Review			
Average number (SD)	2.1 (1.0)	2.5 (1.5)	2.3 (1.4)
Percent 2 or more	63.6%	70.4%	67.7%
Sexual Arrests Prior to SOMTA Review			
Average number (SD)	2.1 (1.2)	3.3 (5.6)	2.7 (1.8)
Percent 2 or more	61.4%	74.1%	75.0%
Sexual Convictions Prior to SOMTA Review			
Average number (SD)	1.9 (1.0)	3.1 (5.9)	2.5 (1.9)
Percent 2 or more	59.1%	63.0%	70.8%
Prison Sentences Prior to SOMTA Review			
Average number (SD)	1.6 (1.0)	1.6 (0.7)	1.7 (1.0)
Percent 2 or more	45.5%	51.9%	47.9%
Probation Sentences Prior to SOMTA Review			
Average number (SD)	0.6 (0.9)	0.7 (0.9)	0.8 (0.9)
Percent 2 or more	13.6%	22.2%	17.7%
Characteristics of Referrals	(n = 45)	(n = 27)	(n = 99)
Static 99 Risk Score			
Percent 0-3	15.6%	3.7%	8.1%
Percent 4-5	28.8%	29.7%	25.3%
Percent 6-7	44.5%	51.8%	53.5%
Percent 8 or higher	11.1%	14.8%	13.1%
Average score (SD)	6.0 (2.0)	6.0 (1.0)	6.0 (2.0)
Victim/Offender Relationship [2]			
Percent unrelated	80.0%	81.5%	79.5%
Percent stranger	37.8%	40.7%	36.4%
Characteristics of Victims in History [2]			
Percent male victim	20.0%	33.3%	38.6%

Notes: SIST Recommended = SIST Team Recommended SIST and the Respondent was released onto SIST. SIST Not Recommended = SIST team did not recommended SIST and the Respondent was released onto SIST. Inpatient = Respondent is confined and has never been on SIST.

1 OMH did not have the criminal history of 1 Respondent that the SIST team recommended SIST and 3 Respondents who were in inpatient treatment.

2 Victim/Offender Relationship was defined as outlined in the Static-99 coding manual.

Part V: Treatment Within Civil Management

Strict and Intensive Supervision and Treatment

Article 10 provides for either confinement in secure treatment or management into the community under a SIST order, depending on the Court's dangerousness determination. New York and Texas are the only states that statutorily authorize the placement of civilly managed sex offenders directly into the community. The Texas statute provides for only community-based civil management of sex offenders, although, in practice, Texas often utilizes local jails and other correctional facilities as community residences for the purpose of civil management.

In New York, the primary goal of SIST is to successfully manage, in the community, sex offenders who are determined to suffer from mental abnormalities that predispose them to commit sexual offenses, but who are not deemed to be dangerous enough to require civil confinement. SIST provides increased public protection through mandatory treatment and intensive supervision, while avoiding the high costs associated with confinement in a secure treatment facility. Since the inception of SOMTA through October 31, 2009, 77 individuals have been subject to a SIST order, 38 of whom were ordered onto SIST between the reporting period of November 1, 2008 and October 31, 2009. Approximately half of the SIST individuals were simultaneously serving a parole term. Of the 77 individuals who have been subject to SIST, nine have subsequently been civilly confined in an OMH secure treatment facility for SIST violations, 13 are in local custody and pending further proceedings for violating their SIST conditions, six are in the custody of DOCS, [14] three are waiting to be released into the community, and 46 remain in the community under active SIST orders (see Table 5).

Table 5
Respondents Placed on SIST as of October 31, 2009

SIST Activity	Number
Total SIST Orders	77
Active SIST Orders	68
Respondents on Parole and SIST (active orders)	35
Respondents on SIST Alone (active orders)	33
Respondents in Community	46
Respondents with a SIST Order – Release Pending	3

Upon receipt of a SIST order, OMH SIST staff, located within BSOET, begins to facilitate reintegration of SIST respondents through community reintegration conference calls among SIST team members (OMH, community based treatment providers, secure treatment facility clinicians, and the Division of Parole). The purpose of the reintegration conference call is to coordinate and share information critical to effective management in the community.

When a sex offender is placed on SIST, s/he agrees to abide by specific court-issued conditions, which are typically based upon the recommendations of Parole in consultation with OMH and the designated community based treatment provider(s). These conditions are extensive and mirror specialized conditions imposed on sex offenders subject to traditional parole supervision and often involve global positioning satellite (GPS) tracking, polygraph monitoring, specification of residence, prohibiting contact with identified past or potential victims, type and frequency of treatment sessions, and other related treatment and supervision requirements. Further specifications generally include abiding by curfews and abstaining from drinking alcohol, using illicit drugs, possessing pornography, and using the internet.

Parole is responsible for monitoring individuals on SIST, implementing the supervision plan, and assuring compliance with court-ordered conditions. Sex offenders placed on SIST often participate in multiple treatment pro-

14 Two of these six are in DOCS custody for a new charge.

grams in the community (see Table 6), and OMH and community based treatment providers work closely with Parole to ensure compliance with all SIST conditions. Supervision/treatment team members participate in monthly interagency case management meetings to review the progress of the individual and ensure that any necessary revisions in the supervision/treatment plan are identified and implemented in a timely manner.

As of October 31, 2009, all SIST participants were referred for sex offender treatment, while 53% were referred for substance abuse treatment, and 30% were referred for mental health treatment (see Table 6).

Table 6
Treatment Services Utilized by Respondents on SIST Orders

Treatment Services	% Referred and Utilized
Sex Offender Treatment	100%
Substance Abuse Treatment	53%
Mental Health Treatment	30%
Case Management Services	8%

All sex offender treatment under SIST is based upon a cognitive-behavioral model, and incorporates a relapse prevention component. The treatment team seeks to assist the offender in gaining and maintaining control over criminal sexual behaviors, deviant conditions and arousal patterns, and other life issues that may contribute to re-offending. Reviews of current sex offender research literature indicates that sexual offense specific treatment, coupled with intensive community supervision and regular use of polygraphs (commonly known as the containment model) is an effective method to manage high-risk sex offenders in the community. The containment model has been found to significantly reduce sexual offense recidivism and, where appropriate, can significantly reduce the cost of civil management relative to placement in secure treatment.

Housing and treatment availability remain significant challenges in the SIST plan development process. A large portion of counties and municipalities throughout the State have residency restrictions for sex offenders.[15] As shown in Table 8, nearly half of SIST participants who are at liberty in the community reside in hotel/motels, shelters or are undomiciled, while a little over one-quarter reside in housing programs. Moreover, many communities throughout New York State have no sexual offense specific treatment services to offer SIST respondents, and other communities with existing services are reluctant to accept SIST cases, especially sex offenders from other counties without qualified sex offender services of their own. The problem is particularly acute in rural areas where the distance between residences and treatment services is often significant and public transportation is unavailable. In many such cases, OMH has to pay for transportation to and from treatment in addition to paying for the sex offender treatment itself.

Table 7
Type of Residence Utilized by Active Respondents on SIST orders as of October 31, 2009

SIST Housing Type	Frequency	Percent
DSS/Undomiciled	8	17.4
Family/Friends	9	19.6
Hotel/Motel	8	17.4
Housing Program	13	28.3
Own House/Apartment	2	4.3
OMRDD	1	2.2
Shelter	5	10.8
Total	46	100

15 At least 19 counties have countywide residency restrictions. In addition, many cities, towns, and villages in counties without countywide residency restrictions have enacted local restrictions.

SIST Violation Process

If a SIST respondent seriously or repeatedly violates the conditions of the SIST order, s/he is taken into custody and a psychiatric evaluation is ordered. As stipulated in SOMTA, once a serious SIST violation has occurred, the psychiatric evaluation must be conducted within five days of the individual being taken into custody (usually in county jail), or the respondent must be released. Per SOMTA, failure to file a petition within the five day timeframe does not affect the validity of the petition or any subsequent action. Therefore, a psychiatric examination may still be conducted after the five day period. The purpose of the psychiatric evaluation is to determine whether modifications are needed to the SIST conditions, or whether the individual is a dangerous sex offender in need of confinement.

Since the inception of Article 10, of the 77 individuals subject to a SIST order, 30 individuals have been charged with violating either the SIST order of conditions or the conditions of parole supervision (the latter can occur when individuals are simultaneously serving a parole term and under a SIST order). Eight of the 30 violations involved inappropriate sexual behavior, two of which resulted in a new criminal charge. Both offenses involved frotteuristic (sexual touching) behavior. These two individuals were returned to DOCS custody on parole violations, the remaining were not charged with a new crime, but modifications were made to their supervision conditions and treatment plans. Six SIST violators were civilly confined, and the remaining 16 violators were pending adjudication at the end of the reporting period.

Treatment in OMH Secure Facilities

Sex offenders under civil management receive treatment within an OMH secure treatment facility if they are placed there pending trial or have been adjudicated as a dangerous sex offender requiring confinement. As of October 31, 2009, 100 respondents were placed in secure treatment facilities pre-trial and awaited adjudication, and 100 were confined by court order in secure treatment facilities as dangerous sex offenders. Three-fifths of those adjudicated as a dangerous sex offender in need of confinement consented to confinement rather than proceeding to trial. Pre-adjudicated placements in secure treatment present unique challenges because they often refuse to participate in treatment. Given the costliness of secure treatment (estimated to be $175,000 per year), consideration should be given to developing less expensive alternatives to secure treatment in OMH facilities for pre-adjudicated Article 10 respondents.

Treatment in OMH Secure Facilities

Section 10.10(a) of the MHL authorizes OMH to accept custody and confine respondents in secure treatment facilities for the purposes of providing care, treatment, and control, following a finding that the respondent is a dangerous sex offender requiring confinement. The law states that secure treatment facilities are separate and distinct facilities from psychiatric hospitals [§7.18(b)], and that its residents must be kept separate from other persons in the care, custody, or control of the Commissioner of OMH (§10.10(e)). Currently, OMH operates Sex Offender Treatment Programs (SOTPs) within the secure treatment facilities located on the grounds of Central New York Psychiatric Center (CNYPC) and St. Lawrence Psychiatric Center (SLPC). The CNYPC program has a capacity of 150 residents, while SLPC currently can accommodate up to 80 residents. In addition, the Manhattan Psychiatric Center (MPC) has a 20-bed ward for respondents attending court proceedings in the New York City area. As of October 31, 2009, 143 respondents were designated to CNYPC and 57 were designated to SLPC (see Table 8).

Table 8
Bed Census as of October 31, 2009

	CNYPC	SOTP SLPC	Total
Pre-Trial	79	21	100
Post-Confinement			
Trial	30	11	41
Consent	34	25	59
Total Confined	64	36	100
Total	143	57	200

Secure Treatment SOTP Model

The secure treatment facilities operate Sex Offender Treatment Programs (SOTPs) within the overarching framework of the Risk-Need-Responsivity Model (RNR). RNR emphasizes matching the residents' risk to the level of services provided, targeting the residents' criminogenic needs in treatment, and maximizing the residents' ability to benefit from treatment by tailoring treatment to their learning style, motivation, abilities, and strengths. Cognitive behavioral therapy and relapse prevention strategies are utilized in the treatment interventions. All interventions are designed to promote growth in key areas such as treatment engagement, general self-regulation, sexual deviancy management, and development of pro-social attitudes and behavior, with the intended outcome of reducing residents' risk of sexual recidivism. The final treatment goal is the residents' safe re-integration into the community.

Four Phase Treatment Program

Treatment offered in the SOTPs is delivered through a four-phase model. The model is designed so that the residents' progress through treatment in an incremental manner, acquiring skills and knowledge that are built upon in subsequent treatment phases. The pace of residents' advancement through the four-phase model is dependent upon their completion of treatment goals of each phase. Phase progression occurs at each resident's treatment pace, rather than a pre-determined time frame.

Treatment Readiness is Phase I of the treatment program. It focuses on developing the skills necessary to successfully participate in treatment. During this phase of treatment, residents are not expected to discuss details of their sexual offending histories.[16] They are expected, however, to admit to having committed a sexual offense, develop familiarity with group processes and their treatment plan, acknowledge a desire to change, and commit to participating in treatment. At the end of Phase I, residents are expected to sign a contract stating that they are willing to participate in psychological testing, including the penile plethysmograph (PPG), if appropriate.

Phase II, Skills Acquisition and Practice, is the phase in which residents begin to explore their sexual offense history, personal values, sexuality issues, arousal patterns, risk factors, and strategies to live an offense-free life. During this phase, residents are required to participate in the group process, acknowledge their sexual offense history, accept personal responsibility for their offenses, identify issues related to deviant arousal patterns and cognitive distortions, and identify their strengths, treatment needs and goals. Moreover, residents in Phase II are required to:

- write and present an offense history and autobiography;
- identify and journal thinking errors;

16 Confined sex offenders are afforded the same confidentiality protections that apply to all other civilly commitment persons when discussing prior offenses during therapeutic sessions.

- demonstrate positive community membership by following the SOTP Code of Conduct;
- examine personal values and how they can affect success in the community;
- engage in behaviors that are pro-social, and refrain from secretive, deceptive and manipulative behaviors;
- express emotions appropriately;
- identify healthy and disordered arousal patterns;
- identify and refrain from engaging in grooming behaviors (behaviors aimed at gaining another individuals confidence in order to assume a position of power);
- show motivation to change disordered arousal pattern; and
- demonstrate an understanding of how to apply a relapse prevention strategy to one's particular offense pattern.

Phase III, Skills Application, is the phase in which residents are expected to internalize and demonstrate pro-social behaviors. In this phase, the residents are required to demonstrate an ability to challenge and replace thinking errors in a variety of situations, interrupt offense-related behavioral patterns, use pro-social coping skills when faced with difficulties, consistently demonstrate appropriate assertiveness skills when interacting with others, and ask for guidance and assistance from others when having difficulties. Additionally, during Phase III of treatment, residents are expected to commit to maintaining healthy relationships.

Phase IV, Community Re-Entry Plan Development, is the phase in which residents develop community re-entry plans. In order to complete this phase of treatment, residents must identify appropriate treatment and community supports, demonstrate realistic short-term and long-term goals, and identify and make contact with a community support system including community service providers and, if appropriate, family and other community members who may assist in the transition process.

At the end of the reporting period (October 31, 2009), over half of the 200 individuals involved in some level of treatment in the secure facilities had progressed to phase II or beyond. Those post adjudication were more likely to be further advanced in treatment. As of October 31, 2009, no residents had progressed to Phase IV of the treatment program (see Table 9).

Table 9
Phase Data for those Designated to SOTP

Facility	CNYPC		SLPC		Total
	Post-Pc/Pre-Trial	Post-Trial (Confinement)	Post-Pc/Pre-Trial	Post-Trial (Confinement)	
Phase I	49	17	17	6	89
Phase II	20	35	3	24	82
Phase III	3	11	0	5	19
Total	72	63	20	35	190

Before a resident can be advanced to Phase IV, the SOTP Director or Chief of Service submits a clinical summary with a recommendation for promotion to the OMH BSOET Treatment Review Committee. Members of the Treatment Review Committee include the Division of Forensic Services' Medical Director, the BSOET Director, the BSOET Chief Psychiatric Examiner/Secure Treatment Services Unit (STSU) Director, and the STSU Assistant Director. The BSOET Treatment Review Committee reviews the case information and makes a determination about whether or not the resident is appropriate for advancement to Phase IV. If the resident is determined not to be appropriate for advancement, the Treatment Review Committee outlines specific treatment goals for the resident to accomplish before she/he can be reconsidered for advancement. Residents will only transition to Phase IV with the approval of both the SOTP and the BSOET Treatment Review Committee.

For residents considered by the SOTP to be approaching completion of Phase IV, the SOTP Director or Chief submits a clinical summary with discharge recommendations to the OMH BSOET Treatment Review Committee. Upon conclusion of its review, the BSOET Treatment Review Committee shares its findings with the Commissioner about whether the resident remains a dangerous sex offender in need of confinement or may be appropriate for court-ordered release under a SIST order.

Core Program Services

A. Assessment:

A rigorous assessment protocol is utilized in the secure treatment facilities in order to determine the residents' risk, sexual and criminogenic treatment needs, as well as any special considerations that impact service provision (e.g., cognitive limitations, mental illness, psychopathy). The assessment evaluates sexual interest and attitudes, personality type, mental health, cognitive limitations, substance abuse, psychopathy, treatment progress (if the resident previously participated in community or prison-based treatment programs), reading comprehension, and treatment readiness.

B. Education/Vocational Training:

The secure treatment facilities provide a wide array of educational and vocational programs that help residents develop the skills necessary for a successful transition to the community. Program targets include academic skills development, pro-social skill development, problem solving, stress and time management, employment readiness, and job skills.

C. Psycho-educational Interventions:

The secure treatment facilities provide psycho-educational groups throughout all phases of treatment. Psycho-educational groups teach residents about their disorders and risk factors, while also providing them with information on coping skills. Although psycho-educational groups are offered throughout all phases of treatment, they are most often used in Phase I. Groups in later phases of treatment tend to utilize cognitive-behavioral treatment modalities to alter thought processes and behaviors rather than merely increasing knowledge.

D. Pro-social Development:

The secure treatment facilities provide a variety of interventions, opportunities, and planned activities specifically aimed at improving the residents' sense of community and pro-social attitudes and behaviors both within the facility and post-discharge. Residents who are able to develop strong pro-social skills will be better prepared for a successful transition to the community and a safe, healthy, and productive life.

E. Process-oriented Treatment:

Once residents have advanced to Phase II, they will have the opportunity to participate in process-oriented group treatment including, but are not limited to, Cognitive-behavioral therapy, principles of the Good Lives Model, anger management, criminal and addictive thinking, recovery/relapse prevention, sexual deviance, arousal reconditioning, and dialectical behavioral therapy. Process groups focus on helping the residents to examine personal issues as they relate to their specific phase of treatment, dynamic risk factors, and individualized treatment goals.

Specialized Treatment Tracks

In keeping with RNR principles, treatment at SOTPs has been tailored to address the specialized needs of several populations of sex offenders. Two specialized treatment tracks have been developed for sex offenders with (1) cognitive impairment/serious and persistent mental illness, and (2) psychopathy.

Sex offenders with these deficits have treatment needs that differ from those without such problems. The following examples demonstrate some of the ways in which treatment is customized for these populations.

- Sex offenders with cognitive impairment may require interventions that are less reliant upon reading and writing, or reading material that is adapted to their functioning level.
- Sex offenders with serious and persistent mental illness may need a period of medication stabilization before they can effectively benefit from group therapies, in addition to customized treatment groups that address their mental illness.
- Sex offenders with psychopathic traits pose a risk to more vulnerable sex offenders within the residential setting. Thus, psychopathic sex offenders are treated in a separate treatment track that is designed to meet their specific needs, some of which include high degrees of impulsivity, poor behavioral controls, and a strong propensity to manipulate people (staff and residents) in their environment.

Currently, 34 residents are receiving treatment in the combined cognitively impaired/serious and persistent mental illness (SPMI) treatment track at SLPC. Of the 34 residents in the combined track, all are diagnosed with at least one serious and persistent mental illness and 27 are assessed with cognitive impairment. The psychopathy track is currently in the final stage of development at CNYPC. Residents are being assessed for their appropriateness for this track. Of those residents who have been assessed, 18 have been deemed as appropriate for the psychopathy treatment track, and approximately 23 additional residents are under consideration and are awaiting completion of the assessment process. Residents not placed in a specialized treatment track receive treatment in a conventional treatment track.

Treatment Aids

Some sex offenders experience intense sexual preoccupation and sexually deviant urges, which do not respond sufficiently to cognitive-behavioral interventions alone. For this population, pharmacological agents can assist by diminishing sexual preoccupation and urges, thereby increasing the offender's ability to benefit from cognitive-behavioral and arousal reconditioning strategies. Consequently, in 2009, OMH developed the capacity to provide pharmacologic interventions involving selective serotonin reuptake inhibitors (SSRI) and antiandrogen therapy (AAT), to augment cognitive-behavioral therapies. Pharmacologic interventions are only undertaken at the request of the resident in consultation with MHLS.

This year, OMH also has expanded the use of PPG in treatment Phases II through IV in order to measure deviant sexual arousal. This measurement informs arousal reconditioning treatment plans, and helps the treatment team to identify individuals who might benefit from SSRI and AAT treatment. In addition, if a respondent is participating in pharmacological interventions, the PPG is used to assess its effectiveness. It is not used to assess for risk of sexual recidivism. If a resident consents to participate in the PPG (a separate consent form is required), the assessment occurs within a laboratory setting in complete privacy. For residents assessed with sexual deviancy by the PPG or other assessment tools, arousal reconditioning interventions may be appropriate. OMH is in the process of developing an arousal reconditioning protocol. Numerous behavioral conditioning methods have demonstrated varying levels of effectiveness over the years in managing/reducing sexual deviance and increasing healthy sexual conduct. When these methods are paired with treatments that address other areas of need, they can be helpful in further reducing some offenders' risk for sexual recidivism.

Annual Reviews

Pursuant to MHL §10.09, the Commissioner of OMH must provide an annual review of each SOTP resident's mental condition in order to determine whether or not the resident remains "a dangerous sex offender requiring confinement." OMH has developed a multi-step annual review process that begins with a notification to the resident of his/her right to petition for discharge, as well as a psychiatric evaluation.

Unless the resident refuses to participate in an annual review, an OMH psychiatric examiner conducts a psychiatric evaluation, typically by video-teleconferencing (VTC), a widely accepted practice in the field of psychiatric evaluation, and submits his or her written report to the BSOET Treatment Review Committee. Upon conclusion of its review and after consultation with the treating facility, the BSOET Treatment Review Committee shares its findings with the Commissioner, or his designee, regarding whether or not the resident remains a dangerous sex offender in need of confinement. The Commissioner, or his designee, reviews all available reports and, if necessary, conferences with the SOTP and the BSOET Treatment Review Committee in order to make a final determination about whether or not a petition for discharge should be filed. The Commissioner (or his designee) notifies the court, in writing, whether or not the resident is currently a dangerous sex offender requiring confinement. After an evidentiary hearing and by clear and convincing evidence, the court makes the final determination regarding whether or not the resident requires continued confinement or can be discharged to the community. It is anticipated that courts will issue SIST orders at the time of discharge.

Between November 1, 2008 and October 31, 2009, OMH completed 57 annual reviews for persons scheduled for review during that time period. In one of the 57 cases, the individual was originally placed on SIST, but had violated the conditions and thus had been admitted into secure treatment. In his annual review, OMH found that the individual was no longer a dangerous sex offender requiring continued confinement. The court concurred and released the offender to the community under a SIST order. In four other cases, OMH recommended continued confinement but the court ordered the individuals to be discharged under SIST orders.

Conclusion

Article 10 provides for the civil confinement of sex offenders in "extreme" cases (MHL section 10.03(b)) in which such confinement is necessary to ensure treatment and protect the public. While approximately half of the sex offenders in secure treatment facilities are still awaiting adjudication, the population of these facilities was stable until the last month of this reporting period. Several factors contributed to the leveling off of the secure facility census including reduced rates of admission following refinement of the assessment process, increased dispositions and increased reliance by the courts on SIST as a mode of treatment and supervision. However, the census began to climb again in October 2009 and, while outside the period of this report, it should be noted that it has continued to climb through December 2009. The end-of-year census for 2009 stands at 214.

The management of SIST continues to present significant challenges due largely to the absence of adequate housing and, in some areas of the state, the lack of access to treatment services. While allegations of SIST violations are relatively common, few have involved sexual reoffending and, in those rare instances, the recidivist offenses were frotteurism. Moreover, few violations have resulted in the admission of sex offenders into secure treatment. It is anticipated, however, that more such admissions may occur as the SIST population continues to grow.

Treatment in OMH secure treatment facilities has advanced over the last 12 months, in part through broader use of PPG and the introduction of pharmacologic interventions. The broader interventions have provided important treatment aids to individuals for whom cognitive behavioral interventions are insufficient. Residents continue to progress through the four phases of treatment and to generally respond positively to treatment interventions.

In the coming year, OMH will continue to work in close collaboration with all of its partners to further ensure the effective implementation of Article 10. Likewise, communities across the State will need to expand access to treatment and housing for this population to help ensure their effective management under SIST orders.

APPENDIX

Table 1-A
SOMTA Qualifying Offenses

Article 10 Sexual Offenses (Includes Felony Attempt and Conspiracy to Commit)

PL SECTION	Crime	Class
130.25	RAPE 3RD DEGREE	E Felony
130.30	RAPE-2ND	D Felony
130.35	RAPE-1ST	B Felony
130.40	CRIMINAL SEXUAL ACT-3RD (AKA Sodomy)	E Felony
130.45	CRIMINAL SEXUAL ACT-2ND (AKA Sodomy)	D Felony
130.50	CRIMINAL SEXUAL ACT-1ST (AKA Sodomy)	B Felony
130.53	PERSISTENT SEXUAL ABUSE	E Felony
130.65	SEXUAL ABUSE-1ST	D Felony
130.65-A	AGGRAVATED SEXUAL ABUSE 4TH	E Felony
130.66	AGGRAVATED SEXUAL ABUSE -3RD	D Felony
130.67	AGGRAVATED SEXUAL ABUSE 2ND	C Felony
130.70	AGGRAVATED SEXUAL ABUSE-1ST	B Felony
130.75	COURSE SEX CONDUCT-CHILD 1ST	B Felony
130.80	COURSE SEX CONDUCT-CHILD 2ND	D Felony
130.85	FEMALE GENITAL MUTILATION	E Felony
130.90	FACILIT SEX OFF/CONTROL SUBST	D Felony
230.06	PATRONIZE PROSTITUTE-1ST	D Felony
255.26	INCEST 2ND	D Felony
255.27	INCEST 1ST	B Felony

Table 1-B
SOMTA Qualifying Offenses

Article 10 Designated Felonies if Sexually Motivated
(Includes Felony Attempt and Conspiracy to Commit)

PL SECTION	Crime	Class
120.05	ASSAULT -2ND	D Felony
120.06	GANG ASSAULT 2ND DEGREE	C Felony
120.07	GANG ASSAULT 1ST DEGREE	B Felony
120.10	ASSAULT 1ST DEGREE	B Felony
120.60	STALKING 1ST DEGREE	D Felony
125.15	MANSLAUGHTER-2ND	C Felony
125.20	MANSLAUGHTER -1ST	B Felony
125.25	MURDER-2ND DEG	A-1 Felony
125.26	AGGRAVATED MURDER	A-1 Felony
125.27	MURDER-1ST DEGREE	A-1 Felony
135.20	KIDNAPPING 2ND	B Felony
135.25	KIDNAPPING-1ST	A-1 Felony
140.20	BURGLARY-3RD	D Felony
140.25	BURGLARY-2ND	C Felony
140.30	BURGLARY-1ST	B Felony
150.15	ARSON-2ND:INTENT PERSON PRESNT	B Felony
150.20	ARSON-1ST:CAUSE INJ/FOR PROFIT	A-1 Felony
160.05	ROBBERY-3RD	D Felony
160.10	ROBBERY-2ND	C Felony
160.15	ROBBERY-1ST	B Felony
230.30	PROMOTING PROSTITUTION-2ND	C Felony
230.32	PROMOTE PROSTITUTION-1ST	B Felony
230.33	COMPELLING PROSTITUTION	B Felony
235.22	DISSEM INDECENT MAT MINOR 1ST	D Felony
263.05	USE CHILD <17- SEX PERFORMANCE	C Felony
263.10	PROM OBSCENE SEX PERF-CHILD<17	D Felony
263.15	PROM SEX PERFORMANCE-CHILD <17	D Felony