2010
Annual Report on the Implementation of Mental Hygiene Law Article 10

Sex Offender Management and Treatment Act of 2007

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Part I: Introduction

This report is submitted to the Governor and Legislature by the Commissioner of the New York State Office of Mental Health (OMH) pursuant to Article 10 of the Mental Hygiene Law (MHL). Specifically, MHL 10.10(i) requires the Commissioner to submit to the Governor and Legislature "a report on the implementation of this article. 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 implementation of MHL Article 10, which was enacted as part of the Sex Offender Management and Treatment Act of 2007 (SOMTA). Part II of this report provides a brief overview of SOMTA. 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 litigation phase of civil management, while Part IV presents information on the adjudication of Article 10 referrals. Part V discusses the treatment aspects of civil management, both within the community under Strict and Intensive Supervision and Treatment (SIST) and in OMH secure treatment facilities. The report concludes with Part VI that summarizes some of the challenges faced since the enactment of Article 10 including managing non-participants in treatment and managing the census of the secure treatment facilities. Requests for any additional information about the Article 10 process should be addressed to the OMH Public Information Office.

Part II: 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 a process for the civil management of certain sex offenders upon completion of their prison terms. SOMTA also requires 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 the New York State Department of Corrections and Community Supervision (DOCCS), including residential treatment.

SOMTA, through the creation of Article 10, established a process to review certain sex offenders in the custody of "Agencies with Jurisdiction" for the purposes of civil management.[1] Article 10 requires the NYS Office of Mental Health (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 designate multidisciplinary staff, case review teams, and psychiatric examiners to identify persons suffering from a mental abnormality that predisposes them to sexual recidivism and who may require civil management.[2] 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.

1 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 Corrections and Community Supervision, the Office of Mental Health and the Office for People with Developmental Disabilities.

2 The definition of mental abnormality under New York's statute is virtually identical to that of other states with Sexually Violent Predator 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 DOCCS (Corrections) who are approaching release, (2) persons under supervision of the DOCCS (Community Supervision) 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 due to be released, and (5) persons convicted of sexual offenses who are in a hospital operated by OMH and were admitted per an Executive Directive (Harkavy cases).

Part III: Assessment of Sex Offenders for Civil Management

OMH 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 1-A 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 investigation 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, as defined in the statute.

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, diagnosis, treatment, and/or management of sex offenders, completes initial reviews of cases. Through this initial assessment, the MDR team determines whether 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, diagnosis, treatment, and/or management 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.[3] The findings from this evaluation are incorporated into a report that is presented to the CRT for final determination as to whether 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 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, 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. During the Article 10 legal proceedings, the psychiatric examiner may speak to risk and protective factors warranting confinement or a SIST determination.[4]

Results of Civil Management Screening by OMH

From November 1, 2009 to October 31, 2010, 1,765 referrals were reviewed by OMH for possible civil management. Of those, 73 referrals (4.1%) were deemed not to have committed a SOMTA-qualifying offense. Of the 1,692 referrals qualifying for review, 1,522 (90.0%) were referred from the DOCCS (Corrections), 151 (8.9%) were referred from the DOCCS (Community Supervision), and 19 (1.1%) were referred from the Office of Mental Health (OMH) or the Office for People with Developmental Disabilities (OPWDD). The 1,692 referrals involved 1,644 unique offenders, as some offenders were referred and reviewed more than once during the reporting time period. Of the 1,644 offenders qualifying for review by MDR, 144 (8.8%) were referred for further review by the CRT, of which 70 (4.3%) were recommended for civil management. The SOMTA-qualifying offenses for offenders reviewed by the MDR and CRT are presented in Table 1.

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

4 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.

Table 1
Characteristics of SOMTA-Qualifying Offense[1]

	No CRT *(n=1499)*	CRT, No CM *(n=75)*	CM *(n=70)*
% PL 130 offense	93.1%	89.3%	84.3%
Rape	40.2%	46.7%	28.6%
Sexual Abuse	27.2%	25.3%	32.9%
Criminal Sexual Act (Sodomy)	19.8%	17.3%	21.4%
Other PL 130	5.9%	0.0%	1.4%
% other sexual offense	0.1%	0.0%	0.0%
% designated felony[2]	6.8%	10.7%	15.7%

Note: No CRT = Case reviewed by the MDR and not referred to the CRT; CRT, No CM = Case reviewed by the CRT, but not recommended for Civil Management; CM = Case reviewed by CRT and recommended for Civil Management.

1 OMH had the data for all cases

2 See Appendix Table A-1 For listing of designated felonies.

Part IV: The Adjudication of Article 10 Referrals

From April 13, 2007 to October 31, 2010, 250 decisions regarding civil management have been issued by the courts. Mental abnormality was found in 226 (90.4%) of the cases, 141 of which resulted in a finding that the respondent is a dangerous sex offender requiring confinement, 82 resulted in SIST determinations, and 3 awaited decision at the close of the reporting period.

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. These placements are not static, as SIST placements may be violated and returned to prison or to secure treatment and secure treatment placements may graduate to SIST or be returned to prison. As of October 31, 2010, 93 respondents were in secure treatment pre-trial awaiting adjudication, 144 were in secure treatment as dangerous sex offenders requiring confinement, and 74 were under active SIST orders. Two-fifths of those adjudicated as a dangerous sex offender consented to confinement rather than proceeding to trial.

Part V: Treatment Within Civil Management

Strict and Intensive Supervision and Treatment

Article 10 provides for either confinement in secure treatment or management in the community under a SIST order, depending on the Court's dangerousness determination. 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. Since the inception of SOMTA (April 13, 2007) through October 31, 2010, 93 individuals have been subject to a SIST order (82 at the initial adjudication), 16 of whom were ordered onto SIST during the reporting period of November 1, 2009 to October 31, 2010. Of the 93 individuals who have had a SIST order, approximately 60% of the individuals were simultaneously serving a parole term. As of the end of the reporting period, 74 individuals were under

a SIST order and 19 were confined in an OMH secure treatment facility for SIST violations. Of the 74 respondents subject to SIST orders, 9 were in local custody, 10 were in the custody of DOCCS on parole violations and pending further proceedings for violating their SIST conditions, 2 were in the custody of OMH, 2 were in the custody of OPWDD, and 51 remained in the community.

Upon receipt of a SIST order, the OMH SIST team, located within the Bureau of Sex Offender Evaluation and Treatment (BSOET), begins to plan reintegration of SIST respondents through community reintegration conference calls with SIST team members (OMH, community based treatment providers, secure treatment facility clinicians, and Community Supervision). 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 Community Supervision 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 community supervison and often involve global positioning satellite (GPS) tracking, polygraph monitoring, specification of residence, prohibiting contact with identified past or potential victims, attendance and participation in 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. Community Supervision 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 programs in the community (see Table 2), and OMH and community based treatment providers work closely with Community Supervision to ensure compliance with all SIST conditions. Supervision/treatment team members participate in monthly interagency case management meetings to review the progress of the SIST respondent and ensure that any necessary revisions in the supervision/treatment plan are identified and implemented in a timely manner.

Table 2
SIST Treatment after Release to the Community

Treatment Services	Frequency	Percent
Sex Offender Assessment & Treatment	93	100.0%
Mental Health Treatment	30	32.3%
Substance Abuse Assessment & Treatment	42	45.2%
Case Management Services	10	10.8%
Total Respondents with a SIST Order	**93**	

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 enhancing and maintaining control over criminal sexual behaviors, deviant arousal patterns, and other life issues that may contribute to re-offending. Current sex offender research indicates that sexual offense specific treatment, coupled with intensive community supervision and regular use of polygraphs (this approach is commonly known as the containment model) is an effective method to manage high-risk sex offenders in the community.[5] The containment model has been found to significantly reduce sexual offense recidivism. Housing, treatment availability, and nursing home placements remain significant challenges in the development of SIST plans. A large portion of counties and municipalities throughout the State have residency restrictions for sex offenders. As shown in Table 3, at the end of the reporting period, nearly one-third of SIST respondents who are at liberty in the community reside in hotel/motels, shelters or are undomiciled, while 28% 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

5 English, K., Pullen, S., & Jones, L. (Eds.) (1996). *Managing adult sex offenders: A containment approach*. Lexington, KY: American Probation and Parole Association.; English, K., Jones, L., & Patrick, I. (2003). Community containment of sex offender risk: A promising approach. In B.J. Winick & J.W. LaFond (Eds.), *Protecting society from dangerous offenders: Law, justice, and therapy* (pp. 265–277). Washington, D.C.: American Psychological Association.

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 several cases, OMH has been paying for transportation to and from treatment in addition to paying for the sex offender treatment itself. In addition, it remains extremely difficult to secure services for medically compromised respondents.

Table 3
SIST Placement after Release into the Community

SIST Housing Type	Number	Percent
DSS/Undomiciled	5	9.8%
Family/ Friends	13	25.5%
Single Room Occupancy	5	9.8%
Hotel/Motel	6	11.8%
Housing Program	14	27.5%
Own House/Apartment	2	3.9%
Shelter	6	11.8%
Total	**51**	

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 SIST violation has occurred, the psychiatric evaluation must be conducted within 5-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 5-day time frame does not affect the validity of the petition or any subsequent action. Therefore, a psychiatric examination may still be conducted after the 5-day period. The purpose of the psychiatric evaluation is to determine whether modifications are needed to the SIST Order (e.g., supervision and/or treatment plan), or whether the individual is a dangerous sex offender in need of confinement.

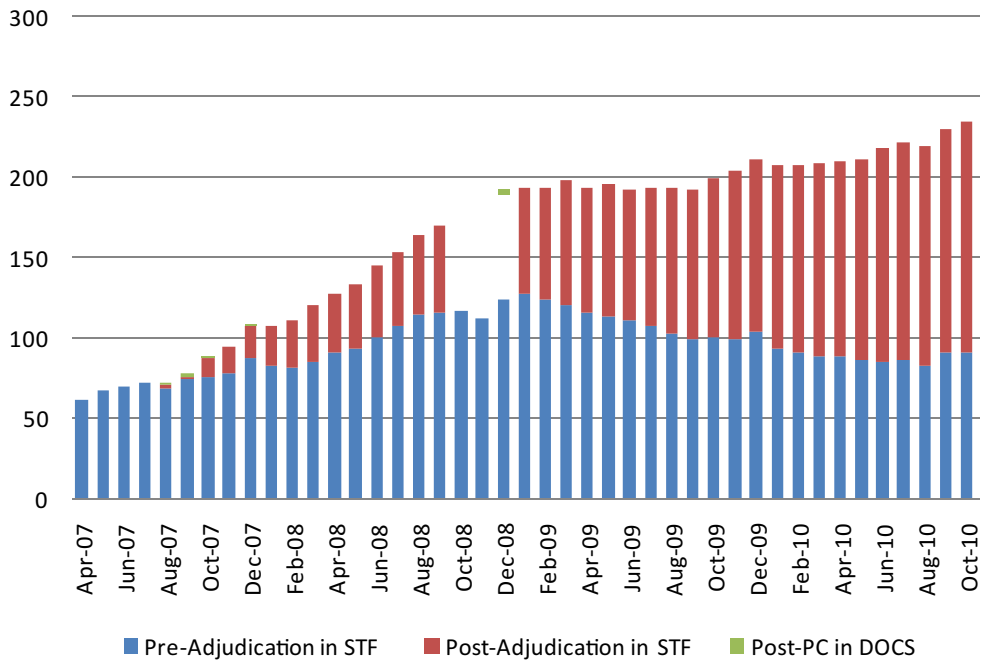
Of the 93 individuals subject to a SIST order since the inception of Article 10, 53 have been charged with violating either the SIST order of conditions or the conditions of Community Supervision (the latter can occur when individuals are simultaneously serving a term of Community Supervision and under a SIST order). Those 53 individuals accounted for 78 SIST violations. While these data show a significant amount of rule violating behavior among SIST participants, a petition to revoke a SIST order or modify the conditions of SIST should not be construed as a failure of the containment model. Rather, such actions represent early interventions in which the team quickly responds to problem behaviors which, if left unchecked, may contribute to offender relapse. After a SIST respondent is taken into custody, the Court ultimately decides if the respondent will return to the community under the same SIST conditions, modified SIST conditions or be civilly confined in an OMH secure treatment facility. OMH and Community Supervision recognize that effective management of sex offenders in the community requires coordinated efforts between agencies and the community treatment providers. Over the past 3 years, OMH and Community Supervision have created numerous procedures and processes to effectively manage and treat respondents who are court ordered to SIST. The nature of the sex offender population poses unique challenges to providing appropriate, effective, and consistent treatment. Case oversight, monitoring, and daily collaborative working relationships between the community based treatment providers, OMH, and Community Supervison have been quite effective since the enactment of Article 10 on April 13, 2007. All parties involved realize that effective communication on a daily basis is essential to ensure proficient oversight for every SIST respondent who the court places in the community.

Thirteen of the 78 violations involved inappropriate sexual behavior (e.g., viewing adult pornography, unapproved adult sexual relationships), 2 of which resulted in a new criminal charge. Both of these offenses involved frotteuristic (sexual touching) behavior. These two individuals were returned to DOCCS custody on violations of Community Supervision. The majority of SIST violations were technical in nature and involved such acts as violating curfew, GPS infractions, and using alcohol or other substances. Of the 53 individuals charged with violating their SIST orders, 14 were returned to the community, 19 were civilly confined, and the remaining 20 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, 2010, 93 respondents were designated to secure treatment facilities pre-trial and awaited adjudication, while 144 were confined by court order in secure treatment facilities as dangerous sex offenders. Two-fifths of those adjudicated as a dangerous sex offender in need of confinement consented to confinement rather than proceeding to trial. The trend in monthly census is shown below in Figure 1. As of October 2010, the total number of respondents designated to Secure Treatment Facilities (STF) and those held in DOCCS post-probable cause exceeded the actual bed capacity of STF.

Figure 1
STF Monthly Population (designated beds) by Adjudication Status



Sex offenders placed in secure treatment pre-adjudication present unique challenges because they often refuse to fully participate in treatment as evidenced by the high percentage of pre-trial respondents in early phases of treatment (see Table 5).

Section 10.10(a) of the MHL authorizes OMH to accept custody of 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 MHL 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 and who are clinically appropriate for placement at MPC. As of October 31, 2010, 156 respondents were designated to CNYPC and 81 were designated to SLPC (see Table 4). In-house, however, CNYPC had 146 respondents, while SLPC had 75 respondents (the remaining 10 CNYPC and 6 SLPC respondents were either temporarily transferred to MPC, local jail, or remained in DOCCS custody).

Table 4
Bed Census as of October 31, 2010

	CNYPC	SLPC	Total
Pre-Trial	70	23	93
Post-Confinement			
Trial	55	31	86
Consent	31	27	58
Total Post-Confinement	86	58	144
Total	**156**	**81**	**237**

Program Mission

The primary mission of the OMH Secure Treatment Facility Sex Offender Treatment Program (SOTP) is to promote community safety by providing secure custody, care, and treatment to persons confined by the courts under the Sex Offender Management and Treatment Act. The SOTP promotes community safety through the provision of quality sex offender treatment services in a secure setting that employs evidence-based methods that are consistent with best practices in the field of sex offender treatment. As new research emerges and best practices evolve, the SOTP will adapt its services accordingly. Treatment services are individualized and strength-based, with the intended outcome of reducing the residents' risks of sexually re-offending, while promoting growth in key areas such as treatment engagement, self-regulation, managing sexual deviancy, and developing pro-social attitudes and behavior. All interventions at the SOTP are delivered in a manner that facilitates self-respect and are aimed at achieving safe reentry into the community.

Secure Treatment SOTP Model

The SOTP's overarching framework is grounded in the Risk-Need-Responsivity (RNR) Model (Andrews, 2006; Andrews, Bonta, & Wormith, 2006).[6] RNR emphasizes matching the residents' risk for sexual recidivism to the level of services provided, targeting the residents' dynamic research-based risk factors (i.e., criminogenic needs) in treatment, and maximizing the residents' abilities to benefit from treatment by tailoring treatment to their learning style, motivation, abilities and strengths (i.e., responsivity factors). In keeping with these principles, the SOTP offers treatment interventions that are individualized, strength-based, and customized to residents' specific risk, criminogenic needs, and responsivity factors. The three core RNR principles are applied in the SOTP as follows:

- *Risk:* SOMTA requires that the SOTP serve offenders who are at the greatest risk of sexual recidivism and con-

6 Andrews, D. A., & Bonta, J. (2006). *The psychology of criminal conduct* (4th ed.). Newark, NJ: LexisNexis; Andrews, D. A., Bonta, J., & Wormith, S. J. (2006). The recent past and near future of risk and/or need assessment. *Crime and Delinquency,* 52, 7-27.

sidered dangerous and likely to commit sex offenses if not confined. Candidates for civil confinement are assessed to be high-risk after a thorough review process that includes a psychological evaluation. The high risk determination is based upon an evaluation of both static (historical) and dynamic (changeable) risk factors for sexual recidivism. The duration, type, and intensity of the treatment interventions provided in the SOTP are tailored to match the residents' overall risk and change in response to any fluctuations in the offenders' dynamic risk factors.

- *Need:* The SOTP primarily focuses interventions on those dynamic risk factors, also referred to as criminogenic needs, demonstrated by research to be associated with sexual offending or criminal recidivism. All offenders who enter an OMH SOTP are clinically evaluated upon admission, entry into Phase II, and at various points throughout the treatment process to determine their specific criminogenic needs and the progress they have made in addressing those needs. Each resident's treatment regimen includes treatment interventions and goals targeting his/her individualized criminogenic needs. Such criminogenic needs may include any of the following: responsibility, sexual deviancy, criminality, self-regulation, treatment and supervision cooperation, lifestyle stability, and development of social supports.
- *Responsivity:* The interventions provided at the SOTP are centered on the residents' needs and delivered in a manner that encourages motivation and builds upon existing strengths. The delivery of such interventions is tailored to the residents' learning style, level of participation, and emotional, psychological, and cognitive abilities.

Four Phase Treatment Program

The Sex Offender Treatment Program uses a four phase treatment 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. Each resident's progression through the four phase treatment model is dependent upon his/her ability to complete the treatment goals of each phase. Phase progression occurs at each resident's treatment pace, rather than a prescribed timeframe.

Phase I: Orientation & Treatment Readiness: This initial phase of treatment focuses on treatment readiness and primarily uses the modality of psycho-educational groups. In this early phase, residents may, but are not expected to, disclose details of their sexual offenses. The assessment process begins in this phase of treatment and specifically seeks to identify the resident's risk level, the appropriate treatment track to meet his/her needs, the resident's assets and deficits in problem-solving and decision-making, as well as the resident's needs and deficits in the areas of education and job skills. All residents develop a Crisis/Initial Safety Plan as part of the orientation process. The Crisis/Initial Safety Plan details known triggers, stressors, and strategies in order to assist the resident in developing skills to manage difficult emotions and impulses. The primary clinical work in this phase of treatment involves laying the foundation for a therapeutic relationship, and addressing behaviors and attitudes that interfere with the resident's ability to fully engage in the program. Residents also work toward developing a basic understanding of the civil management process and the SOTP. When a resident consistently shows a willingness to participate in sex offender treatment, acknowledges having committed a sexual offense, and is willing to sign an agreement to participate fully in both the ongoing assessment and treatment processes, s/he is ready to advance to Phase II.

Phase II: Acquisition & Practice: In Phase II, residents begin to solidify a collaborative and therapeutic relationship with program staff. The key component of the therapeutic relationship between staff and resident is the encouragement of, and expectation that, residents assume increasingly more responsibility for their treatment and individual conduct. With entry into Phase II, residents are introduced to sex offender process-oriented groups. Residents are encouraged, and expected, to examine and detail their criminal and sexual offense histories in an effort to identify the criminogenic factors that contributed to their sexual offending and increase their risk of sexual recidivism. Once residents have acquired an understanding of these factors, program staff assists the residents with addressing those factors and developing pro-social skills. Their pro-social skill development is measured by their progress in treatment groups and their behavior in the residential community. Additionally, residents in this phase of treatment are expected to begin examining underlying deviant arousal patterns. The Penile Plethysmograph

(PPG) is an assessment tool used to assist residents and treatment staff in identifying deviant sexual interest.

Phase III: Skills Application: Entry into Phase III is characterized by the resident's ability to consistently utilize the skills s/he has acquired from the various treatment and rehabilitation groups and programs attended. At this stage of treatment, residents are expected to demonstrate a consistent ability to independently employ emotion/behavior management skills in response to day-to-day stressors and disruptions. Residents should be able to demonstrate appropriate behavior in the treatment environment, void of significant emotional outbursts, antisocial or rule-breaking behavior, threats, manipulation, inappropriate sexual acting out, or acts of violence. Residents in Phase III are expected to engage in an in-depth exploration of sexual deviancy issues and develop and successfully implement strategies to address deviant sexual thoughts and urges. Residents are expected to demonstrate the ability to consistently challenge and replace cognitive distortions and avoid engaging in pre-offense behaviors. Residents are also expected to draw comparisons between how managing stress, day-to-day problems, emotional experiences, and sexual thoughts and desires within the SOTP will differ from managing similar experiences in the community. During this phase, residents should demonstrate that they are able to maintain Phase III treatment goals for at least a period of six months, although some residents will require a longer period of maintenance. A relapse prevention plan addressing all relevant risk factors for sexual recidivism is completed by residents before advancement to Phase IV.

Phase IV: Community Reentry and Planning Skills: Phase IV is characterized by the resident's work in developing a comprehensive Community Reentry Plan in collaboration with the STF treatment team, and on occasion, with the SIST staff. Residents in this phase are expected to detail reasonable and achievable short- and long-term objectives for transition. In doing so, residents identify and address: a) anticipated problems specific to encountering social isolation by their local community, family and friends, b) their level of commitment to adhere to SIST/Community Supervision requirements, c) issues specific to obstacles in obtaining employment, and d) other foreseeable stressors potentially impacting their dynamic risk. Additionally, residents are encouraged to identify in their Community Reentry Plan their support, care, and treatment needs. Residents are expected to finalize their relapse prevention plan for implementation in the community based upon feedback from the STF treatment team and SIST staff. Phase IV is the most individualized of the phases as discharge planning needs to be highly tailored to the individual and the environment to which he or she will return. To date, OMH has established goals and expectations for Phase IV, although no respondents have yet entered that phase. OMH has developed lessons and tasks associated with Phase IV but recognizes that this phase needs to be highly individualized to meet the needs of returning respondents.

At the end of the reporting period (October 31, 2010), over three-fifths of the 235 individuals involved in some level of treatment in the secure facilities had progressed to Phase II or beyond.[7] Those post adjudication were more likely to be further advanced in treatment. As of October 31, 2010, no residents had progressed to Phase IV of the treatment program (see Table 5).

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 Treat-

Table 5
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	48	20	11	8	87
Phase II	20	49	11	44	124
Phase III	1	17	0	6	24
Phase IV	0	0	0	0	0
Total	**69**	**86**	**22**	**58**	**235**

* As of the end of the reporting period, there is 1 Respondent who is Pre-PC and in Phase III and no Respondents in Phase IV.

7 Two additional respondents were designated to STF, but excluded from the table due to their pre-probable cause status and pre-transfer status.

ment 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 Coordinator. The BSOET Treatment Review Committee reviews the case information and makes a determination about whether 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 s/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 OMH Commissioner/designee regarding whether the resident remains a dangerous sex offender in need of confinement or may be appropriate for court-ordered release under a SIST order.

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. Three specialized treatment tracks have been developed for sex offenders with (1) cognitive impairment, (2) serious/persistent mental illness, and (3) 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, 21 residents are receiving treatment in the cognitively impaired track, while 10 are receiving treatment in the serious and persistent mental illness (SPMI) track, both of which are located at SLPC. In CNYPC, residents are being assessed using the PCL-R for their appropriateness in the psychopathy treatment track. As of the end of the reporting period, 21 have been deemed as appropriate for the psychopathy treatment track. Residents not placed in a specialized treatment track receive treatment in a conventional treatment track, which is provided at both facilities.

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.

This year, OMH also has expanded the use of the penile plethysmograph (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. Numerous behavioral conditioning methods have demonstrated varying levels of effectiveness 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 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 interview, an OMH psychiatric examiner conducts a 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 OMH Commissioner, or his designee (Associate Commissioner for Forensic Services), regarding whether or not the resident remains a dangerous sex offender in need of confinement. The Associate Commissioner 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 Associate Commissioner notifies the court, in writing, regarding whether or not the resident is currently a dangerous sex offender requiring confinement.

Part VI: Future Directions

Managing Non-Participants in Treatment

Treatment non-participants continue to present a challenge for OMH staff. Treatment non-participants include those in secure treatment or in the community on SIST who (a) refuse treatment, (b) attend programs, but are not meaningfully engaged in treatment or (c) are disruptive to the treatment process. While motivating individuals to actively engage in treatment is always a challenge within any treatment system, the civil management system, as currently configured, has limited leverage to remove non-participators from the treatment milieu. The problem is compounded by the realities that achieving control of sexual disorders is a difficult process, a portion of the population is highly anti-social, and life in the community can be very inhospitable for this population of offenders. Yet, at the core, the obligation of OMH remains straightforward - to motivate and help this civil population to develop the skills needed to live safely in the community.

Nearly 40% of the patient population in OMH secure treatment facilities is awaiting trial. This population is largely unwilling to actively participate in treatment and is often advised by counsel to minimize participation and avoid disclosure of their sex offending histories. As non-participants, they are often disruptive in treatment and establish poor patterns of behavior that can be difficult to overcome subsequent to adjudication and commitment. Their court cases average over a year to disposition, during which time most respondents make minimal treatment progress. Given the significant cost of secure treatment and the need to maintain a positive treatment environment for those actively working to gain control of their sexual disorders, an alternative to secure treatment at an OMH facility is needed for pre-adjudicated respondents.

More leverage also is needed to effectively address treatment non-compliance of post-adjudicated individuals in the community on SIST and within OMH secure facilities. When the court orders an individual into treatment in

either an OMH secure facility or in the community on SIST, there needs to be clear and certain consequences for violations of that order. While motivation to change needs to be internally driven to be sustained in the long-term, an extensive body of research on treatment for drug addiction has shown that the external leverage of prosecution is often instrumental in overcoming an individual's initial resistance to treatment and bringing order to the treatment milieu. The State of Texas, which relies solely on civil management in the community, has effectively addressed non-compliance by enacting legislation to make it a felony offense to refuse to abide by the court order of conditions, including participation in treatment.

Managing the Census

As noted above, 237 individuals were designated to a secure treatment facility as of October 31, 2010. The two facilities currently operating have a combined capacity of 230 patients. An additional 20 beds are available in the Manhattan Psychiatric Center (MPC) for the temporary placement of Article 10 residents who are attending court proceedings in the New York City area and who are clinically appropriate for placement at MPC. On average, OMH receives 6 designations per month. Thus, the demand for secure treatment beds has already approached current capacity and OMH is seeking to temporarily expand bed capacity in the three pre-existing sites. There will be a need, however, to identify additional treatment sites in the very near future absent a reduction in admissions or increase in releases.

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

APPENDIX

Table 1-A
SOMTA Qualifying Offenses

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

PL SECTION	Crime	Class
120.25	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