Office of
Mental Health

2015

Annual Report on the Implementation of Mental Hygiene Law Article 10

Sex Offender Management and Treatment Act of 2007

SEPTEMBER 2016

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."

Overall, this report serves 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 reviews the assessment of offenders at intake to the Department of Corrections and Community Supervision (DOCCS) custody in order for treatment level decisions to be determined. Part IV of the report summarizes the assessment process employed by OMH to identify sex offenders in need of civil management. Part V presents information on the adjudication of Article 10 referrals. Part VI provides a discussion of the treatment aspects of civil management both within the community under Strict and Intensive Supervision and Treatment (SIST) and in OMH secure treatment facilities (STF). Lastly, Part VII discusses ideas for the future of civil management in New York State.

Below are highlights of the report:

- Only 0.8% of the offenders evaluated under SOMTA deemed not to be in need of civil management and released from DOCCS have been re-arrested for a sexual offense within one-year of release into the community. After three years in the community, just 2.3% have been re-arrested for a sexual offense, and just 3.8% have been re-arrested for a sexual offense at the five-year mark. These rates represent a 33%, 43%, and 47% (respectively) reduction in sexual rearrests when compared to pre-SOMTA sample of New York State sex offenders. This reduction in sexual rearrests lends support to the notion that the Article 10 process results in the civil management of the highest risk offenders, which in turn increases public safety.

- From April 13, 2007, to October 31, 2015, 654 probable cause determinations have occurred, and all but one hearing resulted in an affirmative finding of probable cause.

- From April 13, 2007, to October 31, 2015, the courts rendered decisions in 564 petitions for civil management. Mental abnormality was found in 514 (91.1%) of the cases, 331 of which resulted in a finding that the respondent is a dangerous sex offender requiring confinement, 174 resulted in a SIST determination, and 9 awaited decision at the close of the reporting period.

- In October 2013, OMH, in cooperation with DOCCS, assumed responsibility for identifying and treating a population of high-risk sex offenders while serving their prison term. This treatment program, known as the OMH Prison-Based Sex Offender Treatment Program (PBSOTP), focuses on (1) addressing dynamic risk factors; (2) helping inmates to develop viable community supervision and treatment plans; and (3) providing for continuity of treatment for inmates who are later deemed in need of civil

management. OMH will be assessing the impact of this program on the civil management system as more program participants complete their prison sentences and are subject to review for civil management.

Part II: The Sex Offender Management and Treatment Act

SOMTA was enacted as Chapter 7 of the Laws of 2007. It 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. The purpose of civil management is to provide offenders with comprehensive treatment to address and reduce their risk of sexually reoffending. 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 the Office of Mental Health to designate several levels of clinical review such as multidisciplinary staff, case review teams, and psychiatric examiners to identify persons suffering from a condition or disease that predisposes them to sexual recidivism (referred to as a "mental abnormality") 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 treatment within a confined setting.

Part III: Assessment of Offenders at Intake to DOCCS Custody

Under Correction Law Section 622, as enacted by SOMTA, sex offenders committed to the custody of DOCCS are to be initially assessed by OMH staff knowledgeable about 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 DOCCS for appropriate treatment program placement. In order to comply with these requirements, an evaluation unit was established in 2007 at the Downstate Correctional Facility. The OMH Sex Offender Evaluation Unit (SOEU), located at Downstate Correctional Facility Reception Center, evaluates all inmates entering DOCCS pursuant to a conviction for a sex offense or sexually motivated felony. This task is performed by a team of forensic psychologists trained in sex offender risk assessment.

[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."

The functions of the SOEU were expanded in 2013 to also include the identification of inmates who would be most appropriate for placement in the new OMH-operated Prison-Based Sex Offender Treatment Program (PBSOTP; see Part VII below for additional information on this program). Since 2013, the SOEU has conducted an average of 853 screenings annually. The SOEU completed 839 screenings in the last reporting year, 7.8% of which resulted in recommendations for treatment in the OMH PBSOTP. The remaining inmates were recommended for DOCCS-operated Sex Offender Counseling and Treatment Programs.

Part IV: 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).[3] Each assessment involves the review of multiple records including, but not limited to, police reports, district attorney records, victim statements, court transcripts, pre-sentence investigation reports, parole board hearing minutes, and correctional and mental health records. The goal of the assessment process is to identify and refer sex offenders for civil management 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. Like the MDR team, the CRT is also 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, history of participation in sex offender treatment, 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.[4] 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

[3] 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 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 (i.e., Harkavy cases).

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

management. OMH then issues a Notice of Determination to the relevant parties (e.g., referring agency, OAG, referred individual) noting its findings on the issues of mental abnormality and the need for civil management. 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, and is based upon the report and the testimony of one or more psychiatric examiners. During the Article 10 legal proceedings, the psychiatric examiner may speak to risk and protective factors warranting confinement or a SIST determination.[5]

Results of Civil Management Screening by OMH

From November 1, 2014, to October 31, 2015, 1,635 referrals were reviewed by OMH for possible civil management, involving 1,603 unique individuals. Of the 1,603 unique individuals referred, 152 (9.5%) progressed to the secondary level of review by the CRT, and 43 (2.7%) were recommended for civil management. The SOMTA-qualifying offense categories for offenders reviewed by OMH are presented in Table 2.

Table 2:
Crimes of Conviction for SOMTA-Qualifying Offenders

Rape	43.2%
Sexual Abuse	24.3%
Criminal Sexual Act (Sodomy)	21.7%
Course of Sexual Conduct Against a Child	6.7%
Incest	0.1%
Designated Felony[1]	4.0%

[1] See Appendix Table 1-A for a listing of qualifying sexual offenses and designated felonies.

Post-Release Arrests of Individuals Not Referred for Civil Management

Re-arrest data were available on 7,211 offenders evaluated under SOMTA since its inception, deemed not to be in need of civil management, and released from DOCCS. An analysis was conducted to determine the rates of sexual re-arrest for these offenders[6] during their time in the community (i.e., post their 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.

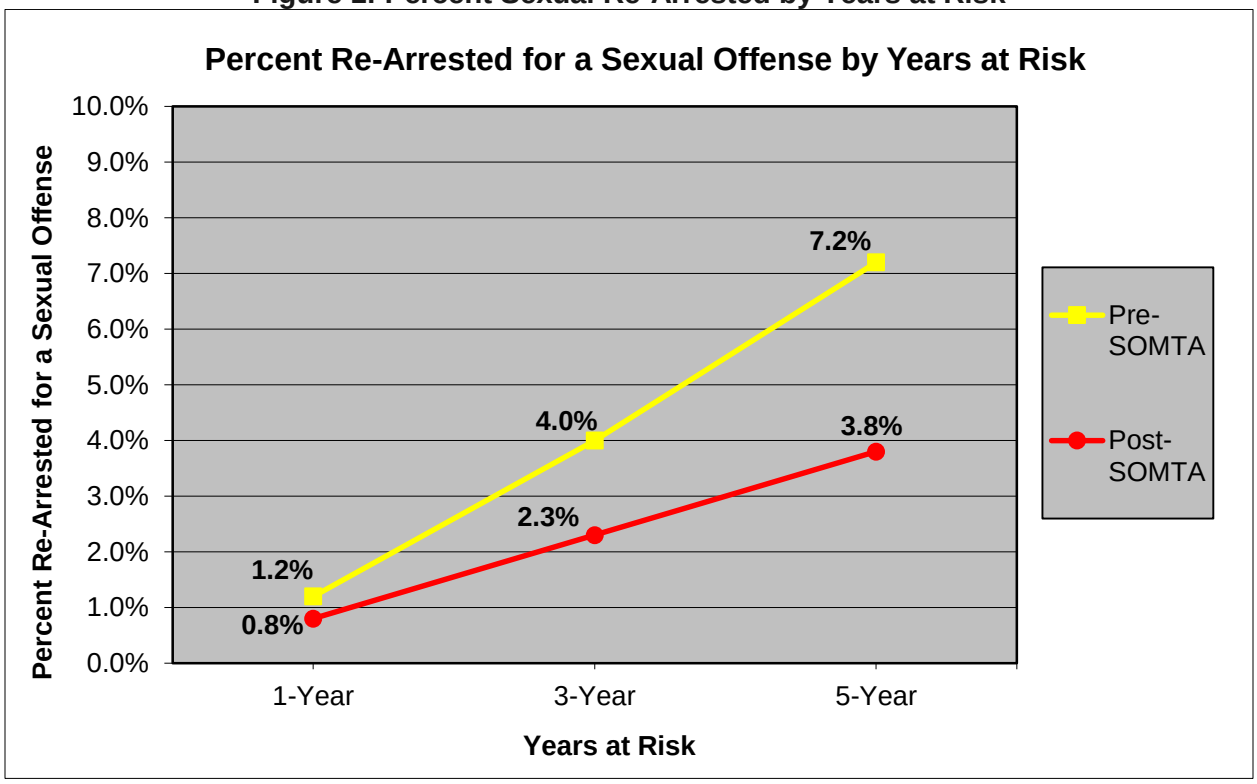
Figure 1 provides a "best estimate" of sexual offense re-arrest rates for the 7,211 offenders. As can be seen (red line on figure), just 0.8% of the offenders were re-arrested for a sexual offense at the one-year mark, just 2.3% were re-arrested for a sexual offense at the three-year mark, and just 3.8% were re-arrested for a sexual offense at the five-year mark. A direct comparison

[5] Sex offenders requiring civil management include "dangerous sex offenders requiring confinement" and those appropriate for 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.

[6] Sexual re-arrest was defined as a NYS registerable sex offense.

can be made with the one, three, and five-year sexual re-arrest rates of 1.2%, 4.0%, and 7.2% (respectively) found in the pre-SOMTA sample of New York State sex offenders in McReynolds and Sandler (2012)[7], as that sample consisted entirely of releases from prison who were convicted of SOMTA-qualifying offenses (yellow line on figure). This low rate of re-arrest for sexual offenses lends support to the notion that the Article 10 process results in the civil management of the highest risk offenders, which in turn reduces the rate of sexual recidivism.

Figure 1: Percent Sexual Re-Arrested by Years at Risk



Part V: The Adjudication of Article 10 Referrals

Probable Cause Hearings

Article 10 provides that within 30 days of the filing of the sex offender civil management petition (unless the respondent consents to a longer time period), the Court shall conduct a hearing (without a jury) 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. A typical hearing will include the testimony of the psychiatric examiner. The respondent is represented by the Mental Hygiene Legal Service (MHLS) and has the ability to hire his own psychiatric expert for this hearing. Probable cause hearings are to occur in the county in which the offender resides (the county where the state correctional facility is located). The respondent can seek a change of venue, however, to the county of conviction underlying the Article 10 referral. According to data provided by the OAG, such changes of venue occur in 70.3% of all cases. While respondents have the right to a probable cause hearing, they may waive that right and consent to a probable

[7] McReynolds, L. S., & Sandler, J. C. (2012). Evaluating New York State's Sex Offender Management and Treatment Act: A matched historical cohort analysis. *Criminal Justice Policy Review, 23*, 164-185.

cause finding. From April 13, 2007 to October 31, 2015, 654 probable cause determinations have occurred, and all but one hearing resulted in an affirmative finding of probable cause.

If probable cause is found, and the respondent is eligible for discharge from DOCCS custody, the respondent will be placed in an OMH secure treatment facility, unless the respondent consents to remain in DOCCS custody.[8]

Article 10 Trial Process

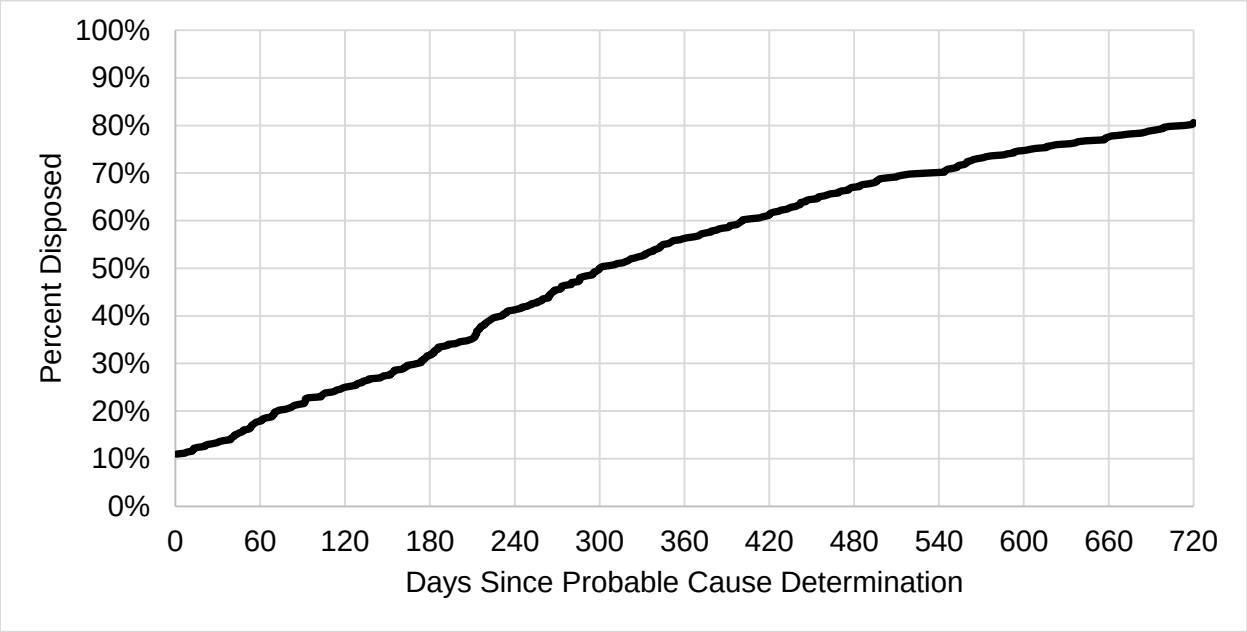
Article 10 respondents have the right to a trial by jury. The jury, or court if a jury trial is waived by the respondent, must determine (by unanimous vote) whether a respondent is a "detained sex offender who suffers from a mental abnormality." The burden of proof, placed upon the OAG, is one of clear and convincing evidence. If the determination is 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 the trial, the standard of proof for the dangerousness determination is one of clear and convincing evidence.

From April 13, 2007, to October 31, 2015, the courts rendered decisions in 564 petitions for civil management. Mental abnormality was found in 514 (91.1%) of the cases, 331 of which resulted in a finding that the respondent is a dangerous sex offender requiring confinement, 174 resulted in a SIST determination, and 9 awaited decision at the close of the reporting period.

Figure 3, below, shows the percent of cases reaching disposition by the number of days since probable cause determination. As can be seen, approximately 56% of the cases were disposed within one year of the probable cause determination. The average case reaches disposition in 439 days (1.2 years), while the median time to disposition is 300 days (approximately 10 months).

Figure 3: Time to Disposition in Article 10 Cases

[8] A 2012 Appellate decision (State v. Enrique T., 93 A.D.3d 158 (2012)) found that a finding of probable cause incorporates a finding of pretrial dangerousness and the OAG does not need to show it's the least restrictive alternative in order to place the respondent in a secure treatment facility pending trial.



Donald DD Court of Appeals Decision

In October 2014, a significant New York State Court of Appeals decision was rendered, which placed certain limitations on the types of psychiatric disorders considered appropriate for sex offender civil management. Specifically, in the *Matter of Donald DD*, the New York State Court of Appeals held that Antisocial Personality Disorder (ASPD) "alone is not a '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'" (emphasis in the original).[9] Essentially, the court held that MHL Article 10 could not be applied to a case where the respondent is diagnosed with ASPD, alone.

As of October 31, 2015, the *Donald DD* decision resulted in challenges to civil management proceedings in 57 cases, all of which were at various stages in the Article 10 adjudication process. Of the 57 cases in which a petition was filed to dismiss the case based on the Donald DD decision, 27 of these petitions were denied, 9 were pending at the close of the reporting period, and the remaining 21 were granted. Only 10 of those respondents with a granted petition were released to the community. The remaining 11 either returned to DOCCS/local jail custody, were pending release from a medical hospital, or were extradited to another law enforcement jurisdiction.

Part VI: Treatment within Civil Management

Strict and Intensive Supervision and Treatment (SIST)

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

[9]Matter of State of New York v. Donald DD, 24 NY3d 174 (2014)

suffer from mental abnormalities that predispose them to commit sexual offenses, but whose level of dangerousness is deemed by the court to be such that they can be treated and supervised in the community.

Since the inception of SOMTA (April 13, 2007) through October 31, 2015, 232 individuals have been subject to a SIST order (174 at the initial adjudication), 57 of whom were ordered onto SIST during the reporting period of November 1, 2014, to October 31, 2015. Of the 232 individuals who were subject to a SIST order, approximately 42% were simultaneously serving a community supervision term when they were first court ordered onto SIST. As of the end of the reporting period, 97 individuals were under an active SIST order, with 91 of them in the community; 35 were subject to both SIST and Community Supervision, while 56 were solely under SIST supervision.

Upon receipt of a SIST court order, the OMH SIST team begins to develop reintegration plans for SIST respondents through community reintegration conference calls with SIST team members (e.g., OMH, community based treatment providers, secure treatment facility clinicians, and DOCCS [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, he agrees to abide by specific court-issued conditions, which are typically based upon the recommendations of DOCCS (Community Supervision) in consultation with OMH and the designated community based treatment provider. These conditions are extensive and often involve global positioning satellite (GPS) tracking, polygraph monitoring, specification of residence, prohibited 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. DOCCS (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 3) based on each client's individual needs (i.e., not all SIST clients require, for example, mental health or substance abuse treatment). OMH and community based treatment providers work closely with DOCCS (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 client and ensure that any necessary revisions in the supervision/treatment plan are identified and implemented in a timely manner.

Table 3: SIST Treatment after Release

	n	**%**
Sex Offender Assessment & Treatment	232*	100%
Mental Health Treatment	67	29%
Substance Abuse Assessment & Treatment	119	51%
Case Management Services	15	6%
Anger Management Services	15	6%

*From the inception of SOMTA to October 31, 2015, 232 individuals were court ordered to SIST. Of those 232, 227 individuals had been released to the

community under a SIST order at the end of the reporting report of October 31, 2015 (5 had received SIST orders, but had not yet been released at the close of the reporting period).

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 client in enhancing and maintaining control over deviant sexual arousal and behavior, antisocial thoughts and behavior, and other factors that may contribute to re-offending. Current sex offender research indicates that sexual offense specific treatment together with intensive community supervision and regular use of polygraph exams (commonly known as the containment model) is an effective method to manage high-risk sex offenders in the community.[10] The containment model has been found to significantly reduce sexual offense recidivism.

SIST Violation Process

If a SIST client seriously or repeatedly violates the conditions of the SIST order, the client is taken into custody, and a psychiatric evaluation is ordered. 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. As stipulated in Article 10, once a SIST violation has occurred, the psychiatric evaluation must be conducted within 5 calendar days of the individual being taken into custody (usually in a county jail). Once the psychiatric evaluation is completed, it is forwarded to the OAG who files either a petition for confinement or a petition to maintain or modify the SIST conditions.

Of the 232 individuals subject to a SIST order since the inception of Article 10, 129 (55.6%) 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; 34.1% of SIST violations were committed by an individual who was also serving a Community Supervision term at the time of the violation). Those 129 individuals accounted for 220 SIST violations. While these data show a significant amount of rule-violating behavior among SIST clients, 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 sexual recidivism. After a SIST client is taken into custody, the Court ultimately decides whether the client will return to the community under the same SIST conditions or modified SIST conditions, or be civilly confined in an OMH secure treatment facility.

The vast 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 220 violations, 8 involved new criminal charges (6 were sexual in nature, while 2 were drug offenses).

Termination of SIST Order

[10] 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; English, K., Pullen, S., & Jones, L. (Eds.) (1996). *Managing adult sex offenders: A containment approach*. Lexington, KY: American Probation and Parole Association.

In accordance with MHL Article 10.11(4)(f), a SIST client may petition every two years for modifications or termination of the SIST order. Since its inception in April 2007, 59 individuals have petitioned for discharge from SIST; 43 petitions have been granted. On average, SIST clients spent 4.2 years on SIST prior to discharge.

Census in OMH Secure Facilities

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. Currently, OMH operates Sex Offender Treatment Programs (SOTPs) within the secure treatment facilities (STFs) located on the grounds of Central New York Psychiatric Center (CNYPC) and St. Lawrence Psychiatric Center (SLPC).[11] The CNYPC program has a bed capacity of 330 residents (only 280 beds were staffed during this reporting period), while SLPC currently can accommodate up to 92 residents. In addition, the Manhattan Psychiatric Center (MPC) has a 25-bed ward for respondents who are awaiting their Article 10 trials and who are either clinically appropriate for placement at MPC or who otherwise have not been ordered into local jail pending trial. As of October 31, 2015, 300 respondents were confined by court order in secure treatment facilities as dangerous sex offenders. In addition, 53 respondents were confined in an STF awaiting adjudication under MHL Article 10.

As can be seen below in Table 4, a slight majority of respondents (154 of 300) confined to secure treatment facilities as dangerous sex offenders were either confined by consent or confined after a violation of SIST. In total, 44 (15%) of the 300 civilly confined residents were afforded periods of time in the community under SIST prior to being civilly confined in a secure treatment facility.

Table 4:
SOTP Bed Census (Designated) as of 10.31.15

	CNYPC	SLPC	Total
Post-Probable Cause/Pre-Commitment	**47**	**6**	**53**
Post-Confinement			
By Trial	115	31	146
By Consent	68	42	110
After SIST Violation	35	9	44
Total Post-Confinement	**218**	**82**	**300**
Confined, Awaiting Release to SIST	**3**	**0**	**3**
Total	**268**	**88**	**356**

Program Mission

The primary mission of the OMH SOTP is to promote community safety by providing secure custody, care, and treatment to persons confined by the courts under MHL Article 10. The SOTP provides quality sex offender treatment services in a secure setting and 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 continues to adapt its services accordingly. Treatment services are individualized and strength-based, with the

[11] MHL Article 10.10(e) states that secure treatment facilities are separate and distinct facilities from psychiatric hospitals (§7.18[b]), and that residents must be kept separate from other persons in the care, custody, or control of the Commissioner of OMH.

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 deviance, 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.[12] 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 styles, abilities, and strengths (i.e., responsivity factors), and by increasing their motivation to engage in treatment. In keeping with these principles, the SOTP offers treatment interventions that are individualized, strength-based, and customized to residents' specific risk levels, criminogenic needs, and responsivity factors.

The ultimate aim of the program is for each resident in secure treatment to work toward a reduction in his or her risk so as to eventually secure a release to the community under Strict and Intensive Supervision and Treatment (SIST). Factors that may impact a resident's rate of progress in treatment include his level of overall risk for future offending, risk-relevant treatment needs, the severity of these needs, his degree of treatment engagement, and his responsiveness to treatment. Treatment advancement is not time-dependent and occurs in accordance with the pace of each resident's effort and success in making observable changes.

Residents are expected to work toward progressing in each of seven treatment target areas assessed as being tied to their specific risk for sexual recidivism. These treatment target areas are evidenced-based factors that have been demonstrated to affect the likelihood of sexual recidivism. Examples of these treatment targets include sexual deviance, antisocial orientation, sexual regulation deficits, intimacy deficits, and general self-regulation difficulties. Residents of the SOTPs must demonstrate change in the areas deemed relevant to their risk and an ability to maintain these treatment gains over time.

Specialized Treatment Tracks

In keeping with principles of risk, needs, and responsivity, treatment at OMH SOTPs have been tailored to address the specialized needs of several groups of residents. Three specialized treatment tracks have been developed for residents with (1) cognitive impairment, (2) serious/persistent mental illness, and (3) psychopathy. Residents with these needs differ from others in how they respond to treatment services. Assignment to one of these specialized tracks is determined by the clinical team and is based upon a thorough assessment of what would most benefit each specific resident. The following examples demonstrate some of the ways in which treatment is customized for these distinct groups.

- Residents with cognitive impairment may require interventions that are less reliant upon reading and writing. This includes adapting materials and programming to meet their cognitive functioning level.

[12] 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.

- Residents with serious and persistent mental illness may need a period of medication stabilization before they can effectively benefit from more conventional forms of group therapies, and/or customized treatment groups that specifically address symptoms of their mental illness.

- Residents with psychopathic traits 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 others (staff and residents) in their environment. Residents with psychopathic traits also require a significant level of behavioral monitoring and accountability to help them meet their needs through pro-social means.

As of October 31, 2015, 69 residents were receiving treatment in the cognitively impaired track (35 at SLPC and 34 at CNYPC), 33 residents were receiving treatment in the serious and persistent mental illness track (28 at SLPC and 5 at CNYPC), and 34 residents were receiving treatment in the psychopathy track (all at CNYPC). The remaining residents were enrolled in the SOTP conventional treatment track.

Treatment Aids

While the core treatment model at SOTP involves cognitive-behavioral programming, some residents experience intense sexual preoccupation and sexually deviant urges that do not respond adequately to cognitive-behavioral interventions alone. For this population, pharmacological agents can assist by diminishing sexual preoccupation and urges, thereby increasing the resident's ability to benefit from cognitive-behavioral and arousal reconditioning strategies. Consequently, in 2009, OMH developed the capacity to provide pharmacological interventions involving selective serotonin reuptake inhibitors (SSRIs) and anti-androgen therapy (AAT), to augment cognitive-behavioral therapies. Pharmacological treatment is offered at varied stages of treatment based upon the individual needs of the resident. While some residents may be capable of managing their sexual deviance without such treatment, others may need medication to be able to effectively engage in even the early stages of treatment. Other residents may require pharmacological treatment as an adjunct safety measure to support their skill-based risk management strategies. Each resident is assessed throughout treatment to determine if and when such treatment may be appropriate.

OMH also continues the use of the penile plethysmograph (PPG) in treatment in order to measure deviant sexual arousal. The PPG assessment is completed with consent of the resident and within a clinical setting that provides complete privacy. PPG results inform arousal reconditioning treatment plans, and help the treatment team to identify individuals who might benefit from SSRI and AAT treatment. In addition, if a resident is participating in pharmacological interventions, the PPG can help the treatment team to assess the effectiveness of these interventions.

The goal of the SOTP is to provide evidence-based treatment services that aim to sufficiently mitigate a resident's risk of sexual recidivism and allow for a resident to transition safely to the community under SIST. In furtherance of this goal, in 2014 OMH implemented policies on the use of the polygraph for post-conviction sex offender testing (PCSOT) as an adjunct assessment method within the SOTP. Research indicates that the use of PCSOT increases disclosure of historical information that might otherwise remain unknown, including identification of the number and type of offenses, the number and type of victims, and the extent of a

resident's sexual history. Polygraph exams are completed by a contracted certified polygraph examiner, when it is deemed clinically appropriate, and are done in accordance with American Polygraph Association standards. Polygraph exams are voluntary (residents sign an informed consent before proceeding with testing) and are not required to complete the treatment program. Results of the polygraph examination are used to assist in the development of comprehensive individualized treatment interventions for residents.[13]

Reviews of Continued Need for Confinement

Each resident committed to SOTP pursuant to MHL Article 10 receives an annual review by OMH to determine whether he remains "a dangerous sex offender requiring confinement." This review includes a psychiatric evaluation by an OMH psychiatric examiner. The psychiatric examiner reviews all historical records and treatment progress notes and, with consent of the resident, completes an interview of the resident. The psychiatric examiner then submits his or her written report to the OMH Commissioner or designee for review who determines whether or not the resident remains a dangerous sex offender in need of confinement. The Commissioner or designee reviews all available reports and, if necessary, conferences with the SOTP in order to make a final determination of whether a petition for discharge should be filed. The Commissioner or designee notifies the court, in writing, regarding his/her determination and the findings of the psychiatric examination. The court holds an evidentiary hearing that often includes testimony from the psychiatric examiner as well as any psychiatric examiner retained by MHLS. Ultimately, the court determines whether the respondent is currently a dangerous sex offender requiring confinement or (unless it finds that the respondent no longer suffers from a mental abnormality) orders the respondent to a regimen of Strict and Intensive Supervision and Treatment (SIST).

During the reporting period, OMH psychiatric examiners completed 195 annual review evaluations. From April 13, 2007, to October 31, 2015, psychiatric examiners completed 1,039 annual review evaluations. In total, the courts have released 76 residents from confinement to SIST since April 2007. The average length of stay in the STF for those residents who were released was 38.2 months (3.2 years). As of October 31, 2015, there have been 91 individuals released from confinement (15 were released from civil management directly from the STF).

Part VII: Future of Civil Management

Prison-Based Sex Offender Treatment Program

In October 2013, OMH, in cooperation with the Department of Corrections and Community Supervision (DOCCS), assumed responsibility for identifying and treating a population of high-risk sex offenders while serving their prison term. This treatment program, known as the OMH Prison-Based Sex Offender Treatment Program (PBSOTP), focuses on (1) addressing dynamic risk factors; (2) helping inmates to develop viable community supervision and treatment plans; and (3) providing for continuity of treatment for inmates who are later deemed in need of civil management. The PBSOTP treatment model, which is synchronized to the treatment in STF, allows those at highest risk of civil management to undergo intensive sex offender treatment while incarcerated.

[13] The use of polygraph exams is standard in the field of sex offender management in the United States and is often used by probation/parole, community sex offender treatment providers nationwide, and in the majority of civil commitment states.

Selection of inmates appropriate for the OMH PBSOTP is conducted by the OMH Sex Offender Evaluation Unit (SOEU) at Downstate Correctional Facility. As described above, the SOEU evaluates all inmates with Article 10 qualifying offenses who are committed to the custody of DOCCS in order to make treatment level recommendations. The screening and assessment process at the SOEU was enhanced in 2013 to include the identification of factors that typically lead to a high likelihood of sexual offense recidivism and that indicates the likely presence of a mental abnormality, as defined under MHL Article 10.

The PBSOTP is located at Marcy Correctional Facility, a medium security facility. Currently, PBSOTP operates a 100-bed program with an additional 50 beds coming online by the end of 2016. The clinical program of the PBSOTP utilizes a Risk-Needs-Responsivity approach, which allows for synchronization with the clinical programming within the OMH-Secure Treatment Facilities (STF) at Central New York Psychiatric Center and St. Lawrence Psychiatric Center. Treatment staff consist mainly of psychologists and social workers who are trained in the delivery of evidence-based treatment for sex offenders. Treatment is individualized and strength-based. It targets dynamic risk factors and is similar in design to the OMH STF sex offender treatment program, including the use of specialized tools for the treatment and assessment of sexual deviance. Treatment success is measured through progress in managing these multiple risk factors and is frequently assessed with standardized tools (e.g., VRS:SO) and observation. The program is designed to be time limited, with a minimum participation time of 24 consecutive months, but with the possibility of engaging in extended programming dependent upon release date and one's level of treatment needs.

As of October 31, 2015, 140 inmates have participated in PBSOTP, for a total of 146 program admissions (i.e., some inmates have been admitted, terminated, and then readmitted to the program). In 2015, 20 inmates who had participated in the PBSOTP were referred for review under MHL Article 10 due to a pending release from prison. Of these 20 cases, 4 were determined to require civil management and were referred to the Office of Attorney General for potential commitment under MHL Article 10.

Appendix 1-A
Article 10 Qualifying Sexual 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	RATE-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
130.95	PREDATORY SEXUAL ASSAULT	A-II Felony
130.96	PREDATORY SEXUAL ASSAULT AGAINST A CHILD	A-II Felony
230.06	PATRONIZE PROSTITUTE-1ST	D Felony
255.26	INCEST 2ND	D Felony
255.27	INCEST 1ST	B Felony

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
121.13	STRANGULATION 1ST DEGREE	C Felony

121.12	STRANGULATION 2ND 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

*MHL § 10.03(6)(s) defines sexually motivated as: "… means that the act or acts constituting a designated felony were committed in whole or substantial part for the purpose of direct sexual gratification of the actor."