2013
Annual Report on the Implementation of Mental Hygiene Law Article 10

Sex Offender Management and Treatment Act of 2007

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New York State
Office of Mental Health

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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 presents information on the adjudication of Article 10 referrals. Lastly, 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 (STF).

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 the Office 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

[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."

and Intensive Supervision and Treatment" (SIST) and to establish secure treatment facilities for persons deemed in need of confinement.

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). [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 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 review 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 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 decision to refer for civil management must be unanimous among CRT members. The CRT does not make recommendations as to whether the

[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 (Harkavy cases).

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

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 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.[5]

Results of Civil Management Screening by OMH

From November 1, 2012 to October 31, 2013, 1,640 referrals were reviewed by OMH for possible civil management. Of those, 81 referrals (4.9%) were deemed not to have committed a SOMTA-qualifying offense. Of the 1,559 referrals qualifying for review, 1,453 (93.2%) were referred from DOCCS (Corrections), 83 (5.3%) were referred from DOCCS (Community Supervision), and 23 (1.5%) were referred from the Office of Mental Health (OMH) or the Office for People with Developmental Disabilities (OPWDD). The 1,559 referrals involved 1,515 unique offenders, as some offenders were referred and reviewed more than once during the reporting time period. Of the 1,515 unique offenders qualifying for review by MDR, 185 (12.2%) were referred for further review by the CRT, of which 105 (6.9%) were recommended for civil management. The SOMTA-qualifying offenses for offenders reviewed by OMH are presented in Table 1.

Table 1:
Crimes of Conviction for SOMTA-Qualifying Offenders

Rape	40.6%
Sexual Abuse	25.2%
Criminal Sexual Act (Sodomy)	21.0%
Course of Sexual Conduct Against a Child	6.9%
Designated Felony[1]	6.3%

[1] See Appendix Table 1-A for a listing of designated felonies.

Part IV: The Adjudication of Article 10 Referrals

From April 13, 2007 to October 31, 2013, 437 decisions regarding civil management have been issued by the courts. Mental abnormality was found in 398 (91%) of the cases, 276 of which resulted in a finding that the respondent is a dangerous sex offender requiring confinement, 112 resulted in a SIST determination, and 10 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.

[5] 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.

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, 2013, 59 respondents were in secure treatment post-probable cause/pre-commitment, 275 were in secure treatment as dangerous sex offenders requiring confinement, and 91 were under active SIST orders. A little over one-third of those adjudicated as dangerous sex offenders 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, 2013, 152 individuals have been subject to a SIST order (112 at the initial adjudication), 18 of whom were ordered onto SIST during the reporting period of November 1, 2012 to October 31, 2013. Of the 152 individuals who have had an active SIST order, approximately 43% were simultaneously serving a parole term when they were first released to SIST. As of the end of the reporting period, 91 individuals were under an active SIST order, 22 of which were subject to both SIST and Parole supervision, while 69 were solely under SIST supervision.

Upon receipt of a SIST order, the OMH SIST team, located within the Bureau of Sex Offender Evaluation and Community Treatment (BSOECT), begins to develop reintegration plans for SIST respondents through community reintegration conference calls with SIST team members (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 2), and 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

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

	n	%
Sex Offender Assessment & Treatment	149*	100%
Mental Health Treatment	50	34%
Substance Abuse Assessment & Treatment	80	54%
Case Management Services	17	11%

*Since the inception of SOMTA until October 31, 2013, 152 individuals were court ordered to SIST. Of that 152, 149 individuals were released to the community under a SIST order at the end of the reporting report of October 31, 2013 (3 had received SIST orders, but were not 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 offender 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.[6] The containment model has been found to significantly reduce sexual offense recidivism.

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. 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 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 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 modify the SIST conditions. 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 evaluation may still be conducted after the 5-day period.

Of the 152 individuals subject to a SIST order since the inception of Article 10, 93 (61.2%) 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; 32.7% of SIST violators were also serving a Parole term at the time of the violation). Those 93 individuals accounted for 156 SIST violations. While these data show a significant amount of

[6] 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.

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.

Sixteen of the 156 violations involved inappropriate sexual behavior (e.g., viewing adult pornography, unapproved adult sexual relationships), four of which resulted in a new criminal charge. Three of these offenses involved frotteuristic (sexual touching) behavior. 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 93 individuals charged with violating their SIST orders, 27 were returned to the community, 42 were civilly confined, 2 returned to DOCCS with new charges, 5 returned to DOCCS on parole violations, 1 was serving Federal Prison time, 4 were released from SIST[7], 3 are deceased, and the remaining 9 were pending adjudication at the end of the reporting period.

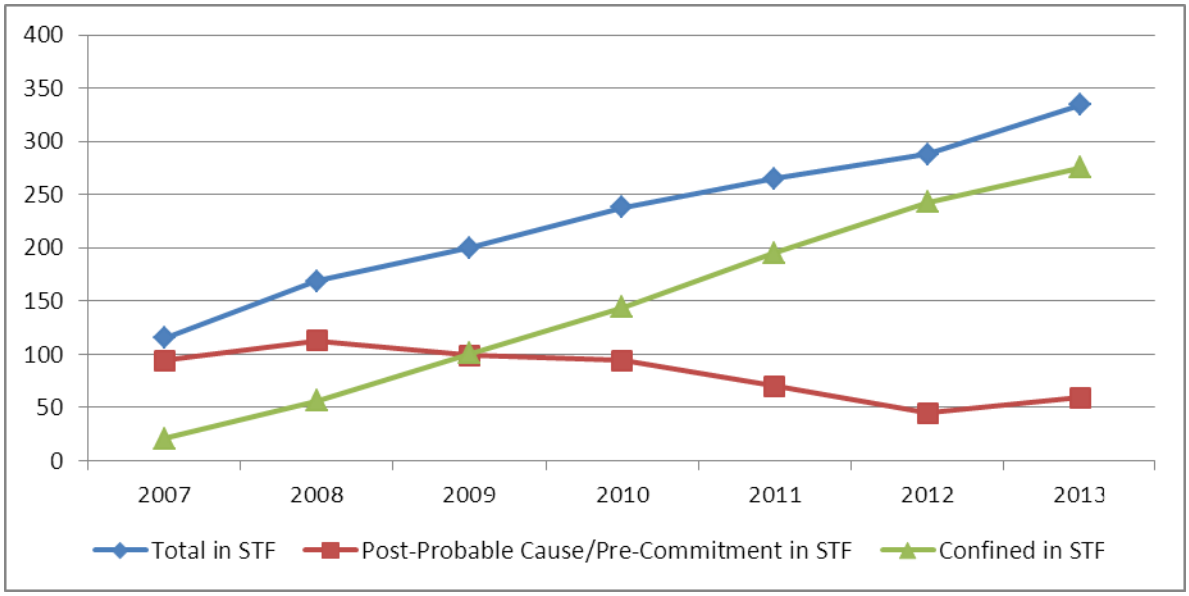
OMH and DOCCS (Community Supervision) recognize that effective management of sex offenders in the community requires coordinated efforts between agencies and the community treatment providers. Over the past 6 years, OMH and DOCCS (Community Supervision) have created numerous procedures and processes 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 DOCCS (Community Supervision) have been quite effective since the enactment of Article 10. All parties involved realize that effective communication on a daily basis is essential to ensure comprehensive oversight of every SIST respondent who the court places in the community.

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, 2013, 59 respondents were designated to secure treatment facilities post-probable cause/pre-commitment, while 275 were confined by court order in secure treatment facilities as dangerous sex offenders. The trend in yearly census is shown below in Figure 1. Sex offenders placed in secure treatment post probable cause/pre-commitment present unique challenges because they often refuse to fully participate in treatment, as evidenced by the high percentage of post probable cause/pre-commitment respondents in early phases of treatment.

[7] The average length of time between last SIST violation and discharge from SIST was 28 months.

Figure 1: Secure Treatment Facility (STF) Yearly Census by Adjudication Status



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 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 bed capacity of 330 residents (only 232 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, 2013, 238 respondents were designated to CNYPC and 96 were designated to SLPC (see Table 3). In-house, however, CNYPC had 219 respondents, while SLPC had 91 respondents (the remaining 19 CNYPC and 5 SLPC respondents were either temporarily transferred to MPC, local jail, or remained in DOCCS custody).

	CYNPC	SLPC	Total
Post-Probable Cause/Pre-Commitment	**51**	**8**	**59**
Post-Confinement			
Trial	106	37	143
Consent	53	39	92
SIST Violation	28	12	40
Total Post-Confinement	**187**	**88**	**275**
Total	**238**	**96**	**334**

Program Mission

The primary mission of the OMH SOTP is to promote community safety by providing secure custody, care, and treatment of persons confined by the courts under the SOMTA. 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 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.[8] 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 one's 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 level, criminogenic needs, and responsivity factors.

Four Phase Treatment Program

The Sex Offender Treatment Program uses a four phase treatment model. The model is designed such that residents progress through treatment in an incremental manner, acquiring skills and knowledge that are built upon in subsequent treatment phases. The treatment phase model is designed to foster residents' motivation to progress in a stepwise fashion through the treatment program, while successively addressing their needs and reducing their risk for recidivism. 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. Residents are expected to meet each of the phase goals, and demonstrate an ability to maintain these goals, prior to advancement to the next phase. Residents may also be moved back to a previous phase if they are unable to maintain the goal(s) of higher phases of treatment.

Phase I - Orientation & Treatment Readiness: This initial phase of treatment focuses on treatment readiness and primarily uses the modality of psychoeducational groups. The focus of this phase is to secure the resident's motivation for treatment, and to secure willingness to change. 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

[8] 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.

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. 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, actively expresses a desire to change and commit to participating in the SOTP, begins showing evidence of such a commitment to change, and is willing to sign an informed consent for treatment, s/he is ready to advance to Phase II.

Phase II - Acquisition & Practice: In Phase II, residents are introduced to sex offender process-oriented groups, and continue to engage in other psycheducational groups to further their behavioral management skills. Residents are encouraged, and expected, to examine and detail their criminal and sexual histories, including sexual offenses, in an effort to help them and their treatment providers continue to identify and clarify the criminogenic factors that contribute to their sexual offending risk. Once residents have acquired an understanding of these factors, program-staff assist the residents in addressing them and developing pro-social skills to manage their risk. 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. In later stages of Phase II, residents are administered the Penile Plethysmograph (PPG). The PPG is an assessment tool used to assist treatment staff in assessing / clarifying deviant sexual interests. Residents may also be administered a sexual history polygraph to confirm the accurate disclosure of their sexual offense histories. The polygraph is also used to verify that all risk factors are being addressed in treatment during the skills acquisition phase.

Phase III - Skills Application: Phase III of treatment is designed to provide continuing supervision and treatment in the secure environment while residents more actively apply their skills in accordance with their identified risk factors. In this phase of treatment, residents will also more actively address higher level skills required to help manage deviant sexual arousal, and are expected to engage in multiple assessments to verify their ability to utilize arousal management techniques in the laboratory setting (i.e., PPG). Residents are expected to take a more active role in applying their risk management skills, without the prompting of staff, and to work toward a more stable presentation of managing their risk factors independently. The overall goal of this phase is for residents to demonstrate consistent use of skills to effectively manage their own risk factors within the secure setting. Residents' independent responsibilities increase in this phase and residents are expected to demonstrate consistent, responsible usage of increased privileges over an extended period of time.

Phase IV- Skills Maintenance and Community Planning: Phase IV of treatment is designed to provide an environment that will more closely mimic the level of programming and responsibilities of living in the community. Residents in this phase of treatment are expected to be able to maintain the goals of prior phases without lapsing into prior behavioral and attitudinal patterns. The changes residents have made by this point should be considered to be stable and extensive with consistent maintenance of such changes over a considerable period of time. Residents are expected to work with facility staff to identify appropriate community placements and begin to devise a more specific release plan that is grounded in the skills they have acquired and have been actively applying over

an extended period of time in the secure facility. 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 support, care, and treatment needs in their Community Reentry Plan. 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 s/he will return. Individuals in Phase IV are also expected to maintain the progress they have made in addressing their risk factors and continue to be consistent in their application of skills without significant lapses in such skill application.

At the end of the reporting period (October 31, 2013), approximately 80% of the 315 individuals involved in some level of treatment in the secure facilities had progressed to Phase II or beyond. Those post adjudication were more likely to be further advanced in treatment. One resident has progressed to Phase IV of the treatment program and was successfully discharged to SIST prior to the end of this reporting period.

Table 4:
Phase Data for those Designated to SOTP (as of 10.31.13)

	CNYPC	**SLPC**
Phase I	54	9
Phase II	140	83
Phase III	24	4
Phase IV	1	0
TOTAL	**219**	**96**

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.

- 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, 2013, 34 residents were receiving treatment in the cognitively impaired track, while 27 were receiving treatment in the serious and persistent mental illness (SPMI) track, both of which are located at SLPC. At CNYPC, residents are assessed using the PCL-R for their appropriateness for the psychopathy treatment track. As of the end of the reporting period, 63 residents were deemed 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 residents experience intense sexual preoccupation and sexually deviant urges, which 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 offender'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 (SSRI) and antiandrogen 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 continues 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. The PPG is not used as a direct measure to assess risk of sexual recidivism. The findings of such evaluations, however, help to determine the degree of risk an individual may pose based on his demonstrated ability to manage sexual deviance, as measured by the PPG. When deemed clinically appropriate, and after a resident consents to participate in PPG testing (a separate consent form is required), the assessment occurs within a laboratory setting in complete privacy.

For residents assessed as having deviant sexual interests by the PPG, behavioral history, self-report or other assessment methods, arousal management 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 residents' risk for sexual recidivism.

The goal of the SOTP is to provide evidence-based treatment services that aim to sufficiently mitigate an offender's risk of sexual recidivism and allow for an offender to safely transition to the community

under Strict and Intensive Supervision and Treatment. In furtherance of this goal, during this reporting period 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 an offender's sexual history. This information results in more accurate risk assessments and the development of comprehensive individualized treatment interventions for residents. Polygraph testing is administered to verify resident's disclosure and is administered during Phases II through IV of the treatment program. Such testing is prescribed when it is deemed clinically appropriate by the facility treatment team or the Treatment Review Committee.

Reviews of Continued Need for Confinement

Pursuant to SOMTA, the Commissioner of OMH must provide reviews 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 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 interview, an OMH psychiatric examiner will interview the resident and will conduct a psychiatric evaluation of the resident based upon the interview and a review of the resident's treatment and historical records. The Psychiatric Examiner then submits his or her written report to the Treatment Review Committee within the Bureau of Institutional Sex Offender Treatment (BISOT). Upon conclusion of its review, and after consultation with the treating facility, the Treatment Review Committee shares its findings with the OMH Commissioner or her designee, regarding 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 and the BISOT Treatment Review Committee in order to make a final determination about whether a petition for discharge should be filed. The Commissioner or designee notifies the court, in writing, regarding whether the resident is currently a dangerous sex offender requiring confinement. During the reporting period, OMH psychiatric examiners completed 170 annual review evaluations. Of the 170 completed evaluations, 3 resulted in a recommendation for discharge to SIST (1.7%). From April 13, 2007 to October 31, 2013, psychiatric examiners have completed 651 annual review evaluations. Of these, 15 resulted in a recommendation for discharge to SIST (2.3%).

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)

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."