2008
Annual Report on the Implementation of Mental Hygiene Law Article 10

Sex Offender Management and Treatment Act of 2007

January 2009

New York State
Office of Mental Health

Michael F. Hogan, PhD
Commissioner

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Executive Summary

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

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

Part I of this report provides a brief history of civil management in New York State and the groundwork that led to the enactment of the Sex Offender Management and Treatment Act of 2007 (SOMTA). Part II summarizes the assessment process employed by OMH to identify sex offenders in need of civil management. Part III reviews the litigation phase of civil management, while Part IV presents information on treatment aspects of civil management, both within the community and in OMH secure treatment facilities. The report concludes with Part V, which offers a summary of the challenges faced since the enactment of Article 10 and recommendations for improving the civil management process.

Briefly, OMH operates two secure treatment facilities, a 150-bed secure treatment facility located within the Central New York Psychiatric Center (CNYPC) and an 80-bed secure treatment facility located on the grounds of St. Lawrence Psychiatric Center (SLPC). These two facilities, along with a 20-bed temporary secure treatment facility within the Manhattan Psychiatric Center (MPC)located on Ward's Island in New York City, have the capacity to provide secure treatment to 250 sex offenders. As of October 31, 2008, 178 offenders were confined to these three secure treatment facilities, many of whom were awaiting final adjudication. Since the enactment of SOMTA, OMH receives a monthly average of 11 new sex offenders for civil management, a rate that is projected to continue into the foreseeable future. As this report notes, a number of these individuals are confined to OMH secure treatment facilities during the pendency of civil management proceedings.

Due to the State's current fiscal climate, OMH has recently adjusted its staffing ratios for its secure treatment facilities to ratios commensurate with its secure forensic psychiatric centers. Nonetheless, the cost of providing care to sex offenders within OMH secure treatment remains high ($17.5 million per 100 residents) and is currently projected to rise to over $100 million by 2012. Since the enactment of Article 10 less than two years ago, OMH is confronted with the need to develop additional secure treatment facility capacity to accommodate the continued growth of this program. OMH recently completed capital renovations at the Mid-State Annex Building located adjacent to CNYPC, thereby adding an additional 150 beds to its secure care treatment facility stock. It is projected that the Annex Building will begin receiving sex offenders in the early part of Fiscal Year 2009-10. Based on current projections, OMH is faced with adding the equivalent of 250 beds every two to three years.

The projected growth of the civil management population raises important public and fiscal policy questions which, given the State's current economic prospects, requires public dialogue as to its sustainability and the most efficient use of

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the State's resources. It is hoped that this report will prompt a dialogue among legislators, policy makers, law enforcement and providers of human services to address this important issue and to explore alternatives to the high cost associated with civil confinement, without compromising public safety.

Over the past 18 months, OMH has faced many challenges and has identified critical issues hampering the effective and efficient implementation of civil management. In the coming year, OMH will continue to work closely with state and local agencies and other stakeholders to find creative and innovative solutions for these issues. We look forward to the support of the Legislature in meeting these challenges. Some of the specific critical issues include the need to:

- Identify alternatives to confinement in expensive OMH secure treatment facilities for those offenders whose civil management proceedings remain pending in the courts;
- Establish intensive and complementary models of sex offender treatment between the Department of Correctional Services (DOCS) and OMH secure treatment facilities for those inmates deemed at high risk for sexual recidivism;
- Develop alternative forms of community housing for sex offenders to ensure respondents' personal accountability and create more options to serve respondents subject to Strict and Intensive Supervision and Treatment (SIST); and
- Assess the impact of residency restriction statutes and ordinances adopted by many localities, as these restrictions may well have deleterious effects on public safety due to impediments they create to supervision and successful community reintegration.

In addition to these critical issues, it is possible that certain sentencing reform initiatives may positively impact the effective and prudent implementation of the civil management process in New York State. For example, changes to sentencing laws that expand the qualifying felony offenses that result in maximum/life indeterminate sentences would enable the Parole Board to make decisions based on meaningful progress in treatment programs. Lengthier sentences may also maximize the opportunity sex offenders have to participate in intensive, long-term sex offender treatment while in DOCS custody which can be operated (for a variety of reasons) at a lower cost than inpatient treatment in an OMH secure treatment facility.

While we recognize the complexities of addressing these concerns, we are also mindful of the enormous economic burden of not doing so. Now that we have had the opportunity to develop the systems needed to effectively assess and treat this population, it is time to take the next step and insure that we are implementing civil management in a way that increases public safety while minimizing costs to the taxpayer.

New York is not alone in facing this vexing public safety issue as it seeks to develop a comprehensive approach to sex offender management. Many states across the nation have crafted legislation to protect the public from persons predisposed to engage in predatory sexual behavior, adopting sex offender registration laws, placing restrictions on where sex offenders may live, requiring intensive supervision (e.g., electronic and GPS monitoring) of sex offenders and passing civil management statutes, with no clear evidence to support that these strategies are the most cost effective means of improving public safety. Review of the multi-state comparative analyses, such as the recently completed study by the Vera Institute (http://www.vera.org/publication pdf/the-pursuit-of safety.pdf) and the periodic reports that describe the experiences of other states with civil management statutes completed by the Washington State Institute for Public Policy (http://www.wsipp.wa.gov/default.asp) are two resources legislators, policy makers and providers may find useful.

2008 Annual Report on the Implementation of MHL Article 10

Introduction

This report is submitted to Governor Paterson and the 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 the Legislature a report on the implementation of this article and that,

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

The following pages serve to review the history and implementation of MHL Article 10, which was enacted as part of the Sex Offender Management and Treatment Act of 2007 (SOMTA). Part I of this report provides a brief history of civil management in New York State and the groundwork that led to the enactment of SOMTA. Part II of the report summarizes the assessment process employed by OMH to identify sex offenders in need of civil management. Part III reviews the litigation phase of civil management, while Part IV presents information on the treatment aspects of civil management, both within the community and in OMH secure treatment facilities. The report concludes with Part V that summarizes the challenges faced since the enactment of Article 10 and recommendations for improvements to the civil management process.

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Part I:
Brief History of Civil Management of Sex Offenders in New York State

SOMTA was enacted subsequent to a series of gubernatorial directives to civilly commit dangerous sex offenders. The gubernatorial directives, issued by then Governor Pataki, were prompted by public calls for the civil commitment of dangerous sex offenders following the murder of Concetta Russo Carriero in 2005. Ms. Carriero was murdered by Phillip Grant, a level three sex offender who had been released from prison after serving 23 years for two rape convictions and an attempted assault conviction. At the time of the murder, Mr. Grant resided in a shelter at the Westchester County Airport.[1] The murder resulted in proposed legislation known as "Concetta's Law," which sought to civilly commitment dangerous sex offenders upon completion of their prison terms. The New York State Assembly and Senate were unable to reach agreement on civil commitment legislation and, in response, Governor Pataki directed OMH and the New York State Department of Correctional Services (DOCS) to utilize MHL §9.27 as a means to civilly commit dangerous sex offenders with mental illness. Section 9.27 provides for the involuntary commitment of people with mental illness to a psychiatric facility based upon the certification of two physicians. In addition, New York State courts have further interpreted the law to require a showing of dangerousness to oneself or others.[2]

The Sexually Violent Predator (SVP) initiative in New York State commenced in September 2005. Under this initiative, OMH was required to conduct a comprehensive record review on all sex offenders who were scheduled for release from DOCS. OMH employed standardized actuarial risk screening instruments to assess for risk of sexual recidivism and to identify potential candidates for civil commitment (as SVPs). These candidates were then screened by two physicians, and a civil commitment determination was made. Because MHL §9.27 permits involuntary hospitalization without a court hearing, these commitments occurred without judicial oversight.[3]

While the risk assessment process employed in the SVP initiative mirrored processes utilized in other states, New York State was fairly unique in its attempt to do so through pre-existing statute (i.e., MHL) rather than enacting separate civil commitment legislation. The use of the MHL involuntary comittment statute avoided judicial involvement in the initial decision to commit sex offenders to secure treatment and allowed for consideration of factors not ordinarily at issue in the civil management of sex offenders (e.g., dangerousness to self).

Challenges to New York's SVP Initiative

In November 2005, the SVP initiative was challenged on procedural grounds in the case of State of New York ex rel. Harkavy v. Consilvio (Harkavy I).[4] Specifically, Mental Hygiene Legal Service (MHLS) argued that MHL §9.27 was not applicable to individuals held in correctional facilities, and that the State should be using Correction Law (CL) §402 to civilly commit sex offenders prior to their release from DOCS. Unlike MHL §9.27, CL §402 required judicial oversight of the commitment process, the appointment of two independent physicians to assess the need for involuntary commitment, and a hearing in which the court determined whether or not an inmate was to be involuntarily committed. While the trial court concurred with MHLS, the Appellate Division reversed the finding, holding that the State properly committed the petitioners under MHL §9.27. MHLS appealed and the Court of Appeals reversed the Appellate Division in November 2006, holding that CL §402 was the appropriate method for evaluating an inmate for involuntary com-

Notes

1 Liebson, R., & Hughes, B. (2005, June 30). Woman Slain in Garage at Galleria. *The Journal News* (Westchester County, NY), p. 1A.

2 See In re Scopes v. Shah, 59 AD2d 203 (3d Dep't 1977).

3 MHL Section 9.27(a) prohibits patients from being involuntarily committed for more than 60 days without court approval.

4 State of New York ex. rel. Harkavy v. Consilvio, 10 Misc3d 851 (Sup Ct, New York County 2005), rev'd 29 AD3d 221 (1st Dep't 2006), rev'd 7 NY2d 607 (2006).

mitment to a psychiatric facility following release from prison. The Court further ordered that those petitioners remaining in OMH custody be afforded an immediate retention hearing pursuant to the MHL, and that future candidates be adjudicated under CL §402.

In December 2005, MHLS challenged, in State ex rel. Harkavy v. Consilvio (Harkavy II),[5] the practice of OMH to civilly commit mentally ill sex offenders directly to a secure hospital. MHLS argued that individuals had a liberty interest in not being confined in a secure hospital and that this right was violated by their commitment to Kirby Forensic Psychiatric Center (Kirby) absent additional statutory authority. Furthermore, MHLS argued that there was no exercise of professional medical judgment that determined these individuals required secure commitment. The State argued that its practice was legal because the law provided for commitment to a hospital and the term "hospital" applies to both secure and non-secure psychiatric facilities. While Harkavy II was pending before the Court of Appeals, SOMTA was enacted which authorized confinement in a "secure treatment facility." Nonetheless, consistent with its holding in Harkavy I, the Court ruled that commitment to Kirby under MHL §9.27 was unlawful. However, in light of the enactment of SOMTA, the Court directed that those so committed needed to be re-evaluated pursuant to the new MHL Article 10.

During the period subject to the SVP Initiative (September 12, 2005-April 12, 2007), a total of 1,212 inmates with sexual offenses were referred to OMH for evaluation for commitment pursuant to MHL §9.27 or CL §402. Of those referrals, 138 were civilly committed. Between September 12, 2005 and April 12, 2007, 17 individuals originally referred for commitment pursuant to MHL §9.27 and subsequently re-evaluated, were released to the community. The remaining 121 individuals (commonly known as "Harkavy cases") were re-evaluated pursuant to the civil management provisions of Article 10. Of the 121, 60 (49.6%) were referred for civil management under the provisions of the new statute. The rest were released to the community or held pending parole revocation proceedings. Table 1 summarizes referrals and commitments for the period of September 12, 2005 to April 12, 2007.

The 19-month period between September 12, 2005 and April 12, 2007 was marked by service expansion, capital construction, litigation and legislative efforts to craft the new statutory scheme under MHL Article 10. With the enactment of SOMTA, a new era of sex offender treatment and management began. During the 19-month period, OMH and DOCS developed the operational infrastructures (i.e., referral, assessment and treatment protocols and services) that served as the foundation for implementation of many of the provisions of the new statute.

Table 1
Individuals Committed under MHL 9.27(a) and CL 402

Commitment Statute	Total Referrals to OMH	Total Commitments	Rate
MHL §9.27	792	127	16%
CL §402	420	46[6]	8.3%
Total	**1,212**	**138**	**11.4%**

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Notes

5 State of New York ex. rel. Harkavy v. Consilvio, 11 Misc2d 1035A (Sup Ct, New York County 2006) rev'd 34 AD3d67 (1st Dep't 2006), rev'd., 8 N.Y.3d 645 (2007).

6 This figure includes both commitments under CL §402 (*N = 11*) and referrals for commitment hearings submitted under CL §402 as of April 12, 2007.

The Sex Offender Management and Treatment Act

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

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

- That recidivistic sex offenders who pose a danger to society should be addressed through comprehensive and integrated programs of treatment and management. {§10.01(a)}

- That some offenders with mental abnormalities are predisposed to engage in repeated sex offenses. These offenders may require long-term specialized treatment modalities to address their risk to re-offend. That treatment should continue following incarceration. In **extreme cases** [emphasis added], confinement will need to be extended by civil process in order to ensure treatment and protect the public. {§10.01(b)}

- That for other sex offenders, it can be effective and appropriate to provide treatment in a regimen of strict and intensive outpatient supervision. Civil commitment should be **only one** [emphasis added] element in a range of responses. {§10.01(c)}

- That the system for responding to recidivistic sex offenders with civil measures must be designed for treatment and protection. It should be based on the most accurate scientific understanding available, including the use of current, validated risk assessment instruments. {§10.01(e)}

- That the system should offer meaningful forms of treatment to sex offenders in all phases of criminal and civil supervision. {§10.01(f)}

- That sex offenders in need of civil commitment comprise a different population with different needs from traditional mental health patients. The civil commitment of sex offenders should be implemented in ways that do not endanger, stigmatize, or divert needed treatment resources away from traditional mental health patients. {§10.01(g)}

In short, the purpose of civil management of sex offenders in New York State is to enhance public safety by continuing to treat and manage mentally abnormal sex offenders who are being released from some type of supervision (e.g., prison, parole, hospitalization), but remain predisposed to recidivate in the absence of such treatment and management.

SOMTA, through the creation of Article 10, established a process to review certain sex offenders in the custody of "Agencies with Jurisdiction" for purposes of civil management.[7] Article 10 requires OMH to evaluate and recommend individuals for civil management and provide treatment to those found by the court to be in need of civil management. More specifically, the statute provides for the Commissioner of OMH to employ multidisciplinary staff, case review teams, and psychiatric examiners to identify persons suffering from a mental abnormality that predisposes them to sexual recidivism and may require civil management.[8]

Notes

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

It also requires OMH to develop treatment plans for persons released to the community under "Strict and Intensive Supervision and Treatment" (SIST) and to establish secure treatment facilities for persons deemed in need of confinement.

Part II: Evaluation of Sex Offenders for Civil Management

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

The first step in the review process is to ensure that the referred individual has been convicted of a qualifying offense. Next, decisions regarding further review are made based upon the individual's score on an actuarial risk assessment instrument known as the Static-99. This highly researched and validated actuarial risk assessment tool is designed to assist in the prediction of sexual recidivism among male sex offenders. The instrument includes measurements of criminal history, age at the time of scheduled release, prior cohabitation with intimate partner(s), victim gender, and victim-offender relationship. OMH staff has been trained in the use of this actuarial instrument by its developer to ensure proper implementation.[9]

Two separate clinical teams are utilized in the civil management review process. Multidisciplinary Review staff (MDR) – comprised of three randomly selected clinicians with expertise in the assessment, diagnosis, treatment, and/or management of sex offenders – undertakes the first level of review by examining the results of the actuarial risk assessment (completed by a team member) and identifying related risk and protective factors. Through this initial assessment, the MDR team determines whether or not the case should be referred to the Case Review Team (CRT) for a more comprehensive, in-depth evaluation.

The Static-99 score is the initial determiner of the path the case will take through the review process. Respondents who score a six or higher on the Static-99 are referred directly to the CRT. Respondents who score less than six on the Static-99 are referred to the MDR team for additional screening. The MDR team checks for the presence of additional research-based risk factors such as sexual preoccupation, general self-regulation problems, prior noncompliance with supervision, deviant sexual interest, and emotional identification with children. If sufficient research-based risk factors are present, the MDR team will refer the case to the CRT for further review.[10]

Notes

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

9 Prior to June 2008, OMH also completed the MnSOST-R actuarial risk assessment, even though the score was never critical to the RARR screening process. The decision to discontinue the completion of the MnSOST-R was in part based on the fact that two of the 16 items in the instrument could not be relied upon as valid for New York State as they were tied to program models that were specific to Minnesota's correctional system and the corresponding developmental sample.

The CRT completes a second level of review. Like the MDR team, it is comprised of three randomly selected professionals (who were not part of the original MDR team) who have expertise in the assessment, treatment, supervision, and/or management of sex offenders. It 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/or during periods of supervision. If the initial CRT review indicates that civil management may be warranted, the CRT requests a psychiatric examiner to evaluate the respondent for the presence of a mental abnormality, as defined by statute. If the CRT determines that civil management is not warranted, a psychiatric evaluation is not requested.

When the CRT requests a psychiatric evaluation, a psychiatric examiner conducts a detailed psychological examination to assess for mental abnormality, using methods approved by clinical and professional practice groups.[11] The findings from this evaluation are written into a report and presented to the CRT for final determination of whether or not the individual is in need of civil management. Based upon information obtained from the psychiatric evaluation, as well as the comprehensive record review, the CRT makes a determination of whether or not to refer the individual to the Office of the Attorney General (OAG) to seek civil management. OMH then issues a Notice of Determination to the referring agency, OAG, and referred individual noting its finding on the issues of mental abnormality, likelihood to re-offend, and the need for civil management.[12]

OMH strives to issue the Notice of Determination at least ten business days prior to an offender's release date. As can be seen in Figure 1, on average, OMH makes these determinations 11 business days prior to an offender's release.

An overview of the entire assessment process is provided in Figure 2.

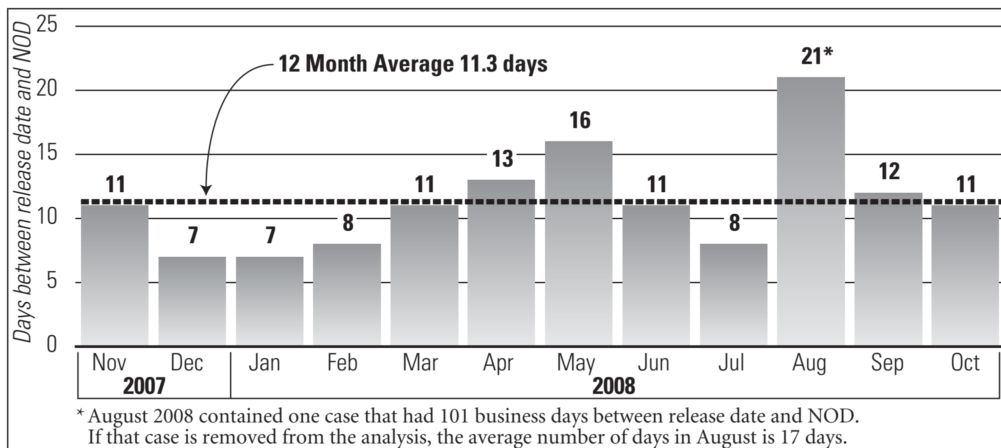

Figure 1
Number of Business Days between Respondent Release Date and the Notice of Determination

Notes

10 While actuarial risk assessment tools have demonstrated considerable accuracy in the arena of sex offender risk assessment, no single actuarial instrument currently captures all potentially relevant risk factors. Thus, the RARR unit has identified other research-based factors that are considered in concert with the Static-99. These research-based risk factors have been shown to correlate with an offender's risk for sexual re-offense. In order to stay current with the ever-growing body of research in the field of sex offender management, research staff employed by OMH regularly culls the literature and informs the RARR staff of issues relevant to sexual recidivism.

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

12 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.

Figure 2
Risk Assessment and Record Review (RARR) Civil Management Review Process

Receive Referral from DOCS, Parole, OMRDD, and OMH
of Individuals Being Released within 180 Days

Yes ↓

RARR clinical staff confirm qualifying offense → No → No further Review

Yes ↓

RARR clinical staff complete the Static-99
unless contraindicated by Static-99 (see 2003 Coding Manual)

↓

Is there evidence of more than one victim in the record?
Does the offense involve Sadism, Murder or Torture?
Are there statements of intent to re-offend? → No → No further Review

Yes ↓

If Static-99 Score of 3 or less:
Does the offense involve Sadism, Murder or Torture?
Are there statements of intent to re-offend?
Is a combination of psychopathy and sexual deviance present?

Static-99 Score of 5 or lower

Yes ↓

Referral to
Multidisciplinary
Review Team (MDR)

↓

Using research-based
factors MDR team determines
whether individual needs
further review by Case Review Team → Yes → Referral to Case Review Team (CRT)
→ No → No further Review

Static-99 score of 6 or more

Yes ↓

Referral to Case
Review Team (CRT)

Yes ↓

Referral for a
psychiatric evaluation
needed → No → No further Review

Yes ↓

Psychiatric evaluation conducted

Yes ↓

CRT makes determination
regarding Civil Management

Yes ↓

Notice of Determination
issued to OAG and Respondant

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Results of Civil Management Screening by OMH

During the 12 month period from November 1, 2007 to October 31, 2008, 1,581 offenders were reviewed by OMH for possible civil management.[13] Of those, 88 offenders (5.6%) were deemed to not have committed a SOMTA-qualifying offense. Of the 1,493 offenders qualifying for review, 1,204 (80.6%) were not referred to CRT for further review, 150 (10.0%) were referred for further review by the CRT, but were not recommended for civil management, and the remaining 139 (9.3%) were recommended for civil management. Characteristics of the offenders' criminal histories, SOMTA-qualifying offenses, and sexual recidivism risk scores are displayed in Tables 2 and 3. As can be seen in the tables, those offenders referred to the OAG for pursuit of civil

Notes

13 The RARR unit completed 1,736 reviews during this same time period, with some individuals being reviewed more than once.

Table 2
Criminal History Information of the Offenders Reviewed by OMH

Offenders Reviewed Under SOMTA 11-01-07 to 10-31-08

Criminal History of Referrals	Not Referred to CRT (n = 1,204)	Referred to CRT, but Not Referred for Civil Management (n = 150)	Referred for Civil Management (n = 139)
Felony Arrests Prior to SOMTA Review			
average # (SD)	2.6 (2.2)	3.5 (2.5)	4.0 (2.7)
% 2 or more	59.4	79.3	87.8
Convictions Prior to SOMTA Review			
average # (SD)	3.8 (3.7)	5.2 (4.1)	5.9 (4.2)
% 2 or more	70.5	92.7	97.8
Felony Convictions Prior to SOMTA Review			
average # (SD)	1.8 (1.2)	2.3 (1.4)	2.6 (1.4)
% 2 or more	45.5	67.3	77.7
Sexual Arrests Prior to SOMTA Review			
average # (SD)	1.2 (0.5)	1.8 (0.9)	2.6 (1.4)
% 2 or more	18.1	60.7	77.0
Sexual Convictions Prior to SOMTA Review			
average # (SD)	1.1 (0.5)	1.7 (0.9)	2.3 (1.3)
% 2 or more	13.8	52.0	70.5
Probation Sentences Prior to SOMTA Review			
average # (SD)	0.5 (0.8)	0.6 (0.8)	0.6 (0.7)
% 1 or more	37.2	46.0	45.3
Prison Sentences Prior to SOMTA Review			
average # (SD)	1.2 (0.7)	1.5 (0.8)	1.7 (0.8)
% 2 or more	19.1	36.0	48.2
Time Spent in DOCS on SOMTA Offense (excl. jail)			
average # of years (SD)	4.8 (4.3)	6.5 (6.2)	6.9 (4.5)
% 3 years or more	53.4	64.6	83.3

* An additional 88 offenders were referred to OMH for SOMTA review, but were deemed to not have committed a SOMTA-qualifying offense.

management have more extensive sexual offense histories, more frequent incarcerations, higher risk scores, and were less likely to have parole time remaining on their sentences than those not referred for civil management.

Post-Release Arrest of Individuals Not Referred for Civil Management

During the 12-month period, 1,354 offenders were evaluated and deemed not in need of civil management. Of those 1,354 individuals, 1,181 had been incarcerated in DOCS and were released

Table 3
Characteristics of the Offenders Reviewed by OMH

Offenders Reviewed Under SOMTA 11-01-07 to 10-31-08

Characteristics of Referrals	Not Referred to CRT (n = 1,204)	Referred to CRT, but Not Referred for Civil Management (n = 150)	Referred for Civil Management (n = 139)
Static-99 Risk Score			
% 0-3	77.2	13.0	5.0
% 4-5	22.3	34.2	25.2
% 6-7	0.5	47.3	52.5
% 8 or higher	0.0	5.5	17.3
average score (SD)	2.3 (1.4)	5.3 (1.6)	6.2 (1.5)
Victim/Offender Relationship[a]			
% unrelated	74.5	97.5	97.4
% stranger	17.3	44.9	52.2
Characteristics of Victims in History			
% male victim	13.6	27.1	37.4
% with "child victim" charge in criminal history	76.4	64.0	77.7
Characteristics of Instant Offense			
% PL 130 offense	89.8	72.0	91.4
Rape	40.5	34.0	35.3
Sexual Abuse	26.6	22.7	26.6
Criminal Sexual Act (Sodomy)	18.2	13.3	23.0
% other sexual offense	0.6	0.7	0.0
% designated felony[b]	9.6	27.3	8.6
Region of Last Conviction Prior to SOMTA Review			
% New York City	28.6	28.0	28.1
% suburban New York City	10.1	10.0	12.2
% upstate	61.3	62.0	59.7
Parole Time Remaining on Sentence			
% with time remaining	70.4	60.0	46.7

* An additional 88 offenders were referred to OMH for SOMTA review, but were deemed to not have committed a SOMTA-qualifying offense.

a Victim/offender relationship was defined as outlined in the Static-99 coding manual.

b See Appendix Table 1-B for listing of designated felonies.

from prison by the close of the reporting period (October 31, 2008). In addition, OMH had available data on another 500 individuals who had been screened prior to November 1, 2007 and had been released from DOCS by the end of the reporting period (October 31, 2008). These two groups of individuals were combined for the purpose of analyzing their success in the community

following release from prison. The questions addressed by this analysis were whether these offenders were re-arrested for any criminal offense and whether they were re-arrested for a sexual offense during their time in the community following 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 3 provides a "best estimate" of re-arrest, for any criminal offense, for individuals who were released from DOCS subsequent to an OMH decision to not pursue civil management. The solid line represents persons with a Static-99 risk score of 1-3 while the dashed line represents those offenders with a Static-99 score of 4 or 5, and the dotted line represents persons with a Static-99 score of 6 or higher. Across all three groups of offenders, approximately 17% were re-arrested during their first year of release. The re-arrest rate was highest for those scoring 4 or 5, for whom it reached approximately 26% at the one-year mark. While those scoring 6 or higher had a lower rate of re-arrest than those scoring a 4 or 5 on the Static-99, the group is relatively small and, thus, provides less stable estimates at this early stage of release.

Figure 4 shows the trend in re-arrest for a sexual offense for the entire group of releases. This analysis is not provided by risk level because the rates of re-arrest were so low that estimates for subgroups lacked stability. Overall, less than 2%

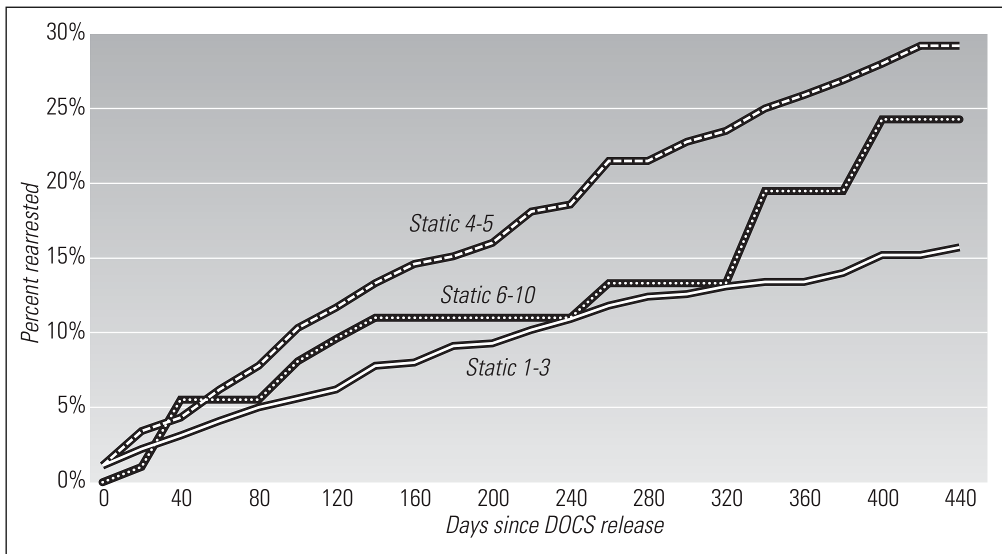

Figure 3
Survival analysis of rearrest for any criminal offense following release from DOCS

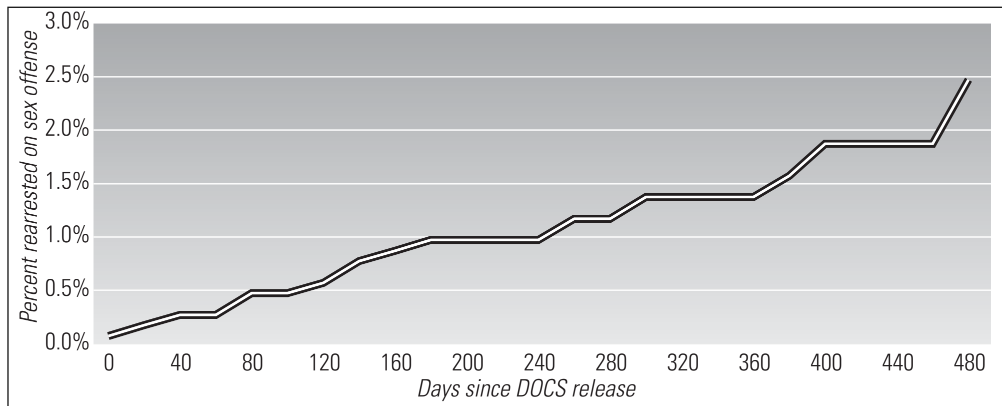

Figure 4
Survival analysis of rearrest for a sex offense following release from DOCS

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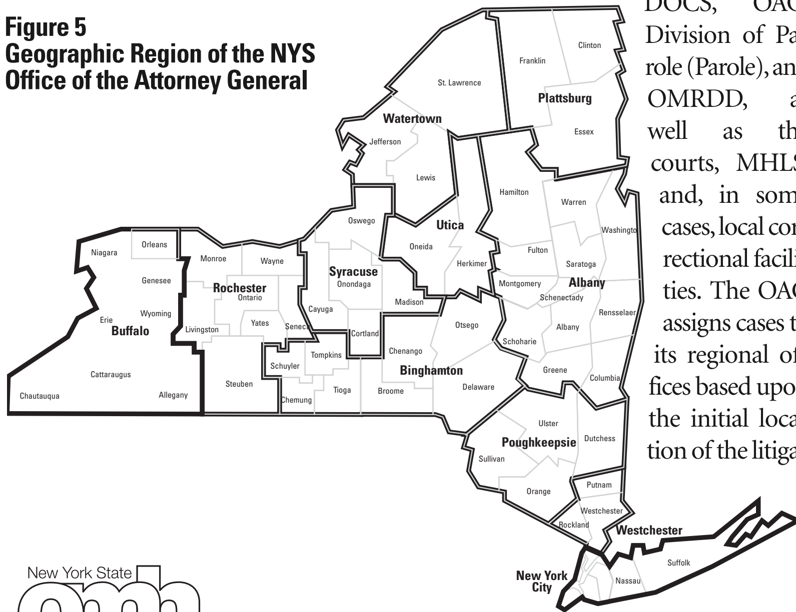
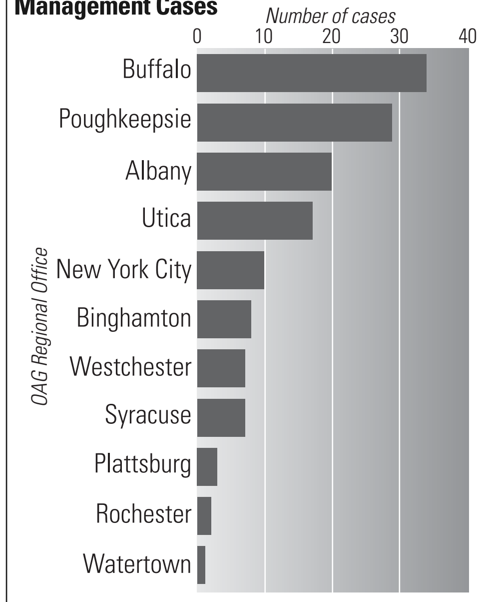
were re-arrested for a sexual offense at the one-year mark. More "time at risk", however, is needed to reliably discern differences in patterns of sexual recidivism across risk groups.[14]

Part III: The Adjudication of Article 10 Referrals

Between the effective date of Article 10 (April 13, 2007) and October 31, 2008, OMH referred 291 sex offenders to the OAG for civil management adjudication, 139 of whom were referred during the reporting period November 1, 2007 thru October 31, 2008.[15] Critical junctures in the adjudication process include the probable cause determination, the placement of the respondent in secure treatment pending trial, a pre-trial SIST investigation, and the bifurcated trial in which the issue of mental abnormality is litigated separately from the issue of dangerousness. Each juncture requires the coordinated efforts of many parties including OMH, DOCS, OAG, Division of Parole (Parole), and OMRDD, as well as the courts, MHLS, and, in some cases, local correctional facilities. The OAG assigns cases to its regional offices based upon the initial location of the litigation which is driven by the geographic location of an inmate within the prison system(see Figure 5). The geographic distribution of the cases referred over the last 12 months is presented above in Figure 6. As shown, at their inception, the cases are most commonly assigned to the Buffalo region, followed by Poughkeepsie, Albany, and Utica.

Figure 5
Geographic Region of the NYS Office of the Attorney General





Probable Cause Hearings

Article 10 provides that within 30 days of the filing of the sex offender civil management petition, the court shall conduct a hearing (without a jury) to determine whether there is probable cause to believe the respondent is a sex offender with a mental abnormality, as defined by statute. The hearing is to commence no later than 72 hours from the date of the respondent's anticipated release, unless the failure to commence the hearing was due to the respondent's request, action, or condition, or occurred with his or her consent.

Notes

14 A 2% sexual rearrest rate at the one-year mark is generally comparable to the rates found in other recent studies of sexual recidivism. It is worth noting that sexual recidivism appears to have decreased over the past few decades. For example, a large number of studies examining the sexual recidivism rates associated with Static-99 scores have shown that while the ability of the Static-99 to rank offenders according to relative risk is reasonably consistant across samples and settings, the observed recidivism rates vary across studies. Specifically, the average recidivism rates associated with each risk level are lower in contemporary samples (1990s and more recent) than in the original developmental samples who were released from prison during the 1970s and 1980s.

15 Sixty of the cases referred for civil management were "Harkavy cases" that were re-evaluated under Article 10.

Although the main statutory purpose of the probable cause hearing is to determine whether there is probable cause to believe that the respondent is a sex offender who suffers from a mental abnormality, a federal District Court has ruled that the State also needs to show current dangerousness at the probable cause stage in order to place the respondent in secure treatment pending trial.[16] A typical hearing will include the testimony of the psychiatric examiner, followed by cross examination by MHLS. In some cases, MHLS may have retained its own psychiatric expert to assess the respondent and, if so, that expert may testify as well. On rare occasions, the OAG may also retain a psychiatric expert (other than the OMH psychiatric examiner), who also may testify at the probable cause hearing.

Probable cause hearings are to occur in the county in which the offender resides and the "residence" is usually a state correctional facility. The respondent can seek a change of venue, however, to the county of conviction underlying the Article 10 referral. While respondents have the right to a probable cause hearing, they may waive that right and consent to a probable cause finding.

Table 4 shows the number of probable cause determinations by month since the inception of Article 10 and further breaks down the determinations into those resulting from waiver and those resulting from a hearing. As can be seen, over the last 12 months (November 1, 2007 to October 31, 2008), there have been 170 probable cause determinations and the average number of monthly determinations has increased. Furthermore, a little over three-quarters of these determinations followed a hearing. All but one probable cause hearing resulted in a finding of probable cause that the respondent was a dangerous sex offender who suffers from a mental abnormality.

The data presented earlier in Figure 6 illustrate the geographical dispersion of the Article 10 caseload at their inception and the logistical challenge faced by OMH in transporting both psychiatric examiners and respondents to the various court proceedings. OMH psychiatric examiners are located in Albany, Rochester, and Poughkeepsie. When schedules permit, they are assigned to cover cases in which the respondent is incarcerated in their region of the State. However, respondents often move for a change in venue either before or subsequent to the probable cause hearing, requiring

Table 4
Probable Cause Determinations by Month[17]

	Probable Cause Determinations		
	Waived	**Not waived**	**Total**
Apr-07	0	2	2
May-07	1	7	8
Jun-07	0	5	5
Jul-07	0	3	3
Aug-07	2	7	9
Sep-07	1	10	11
Oct-07	10	13	23
Nov-07	3	4	7
Dec-07	7	15	22
Jan-08	3	10	13
Feb-08	7	12	19
Mar-08	5	10	15
Apr-08	6	13	19
May-08	2	9	11
Jun-08	0	14	14
Jul-08	2	15	17
Aug-08	2	9	11
Sep-08	3	8	11
Oct-08	1	10	11
Total	**55**	**176**	**231**

Notes

16 While Article 10 stipulates that, upon a finding of probable cause, the respondent is to be transferred to secure treatment when released from custody, the court in MHLS, et ano. v. Spitzer, et al. (U.S. District Court, Southern District, 11/16/07) enjoined the State from placing respondents in secure treatment absent a showing of current dangerousness.

17 Probable cause hearing data come from probable cause orders, SIST orders, confinement orders, and the OAG tracking spreadsheet dated 11/19/08.

OMH psychiatric examiners to travel significant distances to testify in court proceedings. According to data provided by the OAG, such changes of venue occur in 46% of all cases.[18] For example, a psychiatric examiner from Rochester may conduct an interview in Attica Correctional Facility, but may need to travel to New York City to testify due to a change in venue.

During Fiscal Year 2008-09, OMH will spend an estimated $550,000 to transport respondents to and from court hearings and other appointments. In addition, the agency is expending an estimated $80,000, annually, for psychiatric examiner travel (i.e., daily expenses and transportation costs). The latter figure does not account for examiner salaries nor does it include the cost of the purchase and maintenance of automobiles used by the examiners. The fiscal impact of changes in venue and the geographical spread of probable cause hearings could be greatly reduced through greater use of videoteleconferencing (VTC). As noted in a recent report authored by Chief Judge Judith Kay and Chief Administrative Judge Ann Pfau, the organized bar has advocated for greater use of VTC in civil matters.[19] This court system report also recommends greater use of VTC in some criminal matters, even in circumstances in which the defendant opposes such usage. Although the Unified Court System has been encouraged to employ VTC, such "electronic appearances" have been sparingly used in Article 10 proceedings. This technology has been successfully used in other litigation contexts and is routinely used in New York State and in many other states to provide clinical evaluations and primary direct clinical care where it is typically referred to as "telepsychiatry." Its expanded use in Article 10 proceedings would considerably reduce the fiscal impact of changes in venue and the geographical spread of probable cause hearings.

Pre-trial Placement in Secure Treatment

A probable cause finding results in the placement of the respondent in an OMH secure treatment facility upon his release from incarceration, where he will remain until a final disposition occurs.[20] However, the placement of respondents in OMH secure treatment while awaiting trial often proves unproductive because respondents are frequently unwilling to fully participate in treatment programming prior to adjudication. For example, staff at Central New York Psychiatric Center (CNYPC) estimates that while 90% of the pre-trial respondents attend group counseling, 25% refuse to participate in any discussions and another 50% refuse to complete any written assignments. Thus, at least 75% of respondents are not meaningfully participating in treatment and their lack of participation is disruptive to the treatment groups.[21]

The problems presented by pre-trial respondents are compounded by the protracted nature of Article 10 litigation. Figure 7, on page 15, provides an estimate, through use of survival analysis, of the percent of cases reaching disposition by the number of days since probable cause determination. An estimated fifty percent of the cases are disposed within 210 days of the probable cause determination.

Given the high cost of secure treatment and the low treatment participation rate of pre-trial Article 10 respondents, the State should seek an alternative means of retaining control over this population without expending scarce treatment resources and disrupting the treatment of the adjudicated Article 10 population.

Notes

18 According to data maintained by the OAG, 106 cases involved a change of venue, 57 of which occurred pre-probable cause and 49 post-probable cause. Cases were most likely to be moved to Bronx, Kings and Monroe counties.

19 Kaye, J., & Pfau, A. (2008). *Green justice: An environmental action plan for the NYS court system.* Retrieved November 17, 2008, from http://www.nycourts.gov/whatsnew/pdf/NYCourts-GreenJustice11.2008.pdf.

20 The structure and content of the treatment is described infra.

21 Respondents in pre-trial status often report that they are refusing to actively participate in treatment based upon the advice of their MHLS lawyer. While OMH treatment programs do not seek to elicit information to help inform the civil management determination, information divulged by respondents during the course of treatment is not protected and, if requested, would be made available to the court with jurisdiction over the Article 10 case. Moreover, in order to move into the second phase of treatment, participants must fully disclose their sexual offense histories and be willing to participate in psychological testing, including the Penile Plethysmograph (PPG) and Polygraph. Pre-trial respondents are rarely willing to meet these conditions.

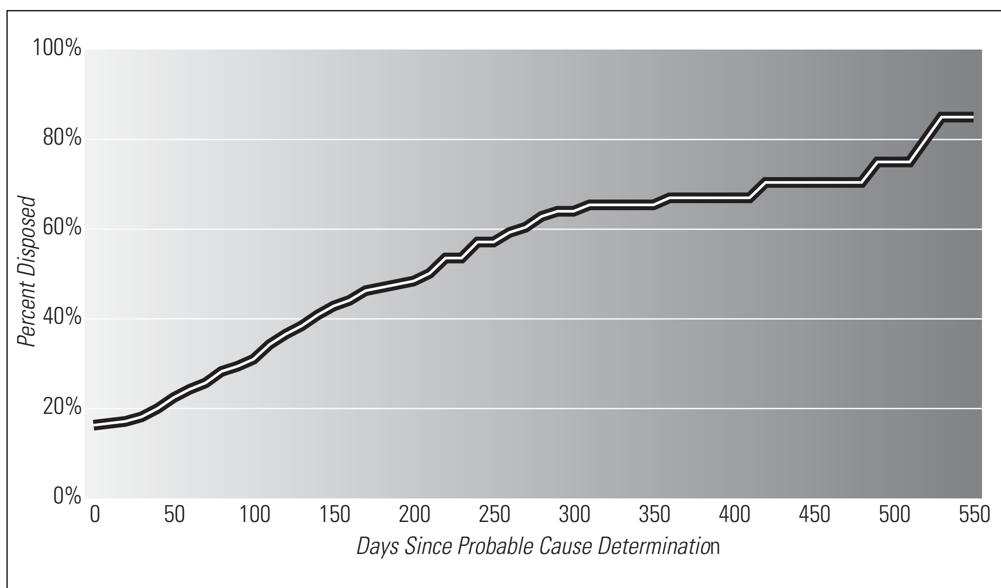


Figure 7
Survival Analysis of Time to Disposition in Article 10 Cases

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, 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" rather than "beyond a reasonable doubt," which is the standard that applies in criminal proceedings and civil commitment proceedings in many states.[22] If the jury, or court if a jury trial is waived, finds that the respondent suffers from a mental abnormality, the trial judge must determine whether the respondent is a dangerous sex offender requiring confinement or a sex offender requiring SIST. As with the earlier phase of trial, the standard of proof for the dangerousness determination is one of "clear and convincing evidence."

As of October 31, 2008, 33 civil management trials have been completed. Mental abnormality was found in 28 (84.8%) of the trials, 10 of which resulted in a finding that the respondent is a "dangerous sex offender requiring confinement" and three of which resulted in SIST determinations (15 cases were still pending a "dangerousness" determination).

Part IV: Sex Offender Treatment

As noted above, sex offenders under civil management will 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 SIST. As of October 31, 2008, 122 respondents were designated to secure treatment pre-trial and awaited adjudication, 56 were designated to secure treatment as dangerous sex offenders requiring confinement and 36 were under active SIST orders.[23] Over four-fifths of those adjudicated as a dangerous sex offender consented to confinement rather than proceeding to trial.

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Notes

22 A "beyond a reasonable doubt" standard is used in civil commitment court proceedings in 11 states including Arizona, California, Illinois, Iowa, Kansas, Massachusetts, Missouri, South Carolina, Texas, Washington, and Wisconsin.

23 Nine of the 122 pre-trial designations to secure treatment were still awaiting a probable cause determination. These nine individuals were Harkavy cases and had entered the treatment system prior to the enactment of Article 10.

Strict and Intensive Supervision and Treatment (SIST)

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

The primary goal of SIST is to successfully manage, in the community, sex offenders who are determined to suffer from a mental abnormality that predisposes them to commit sexual offenses, but who are not deemed to be dangerous enough to require civil confinement. SIST offers increased public protection through mandatory treatment and close supervision, while avoiding the high costs associated with confinement in secure treatment. As of October 31, 2008, 39 individuals have been subject to a SIST order, 28 of whom were ordered onto SIST between the reporting period of November 1, 2007 and October 31, 2008. Over half of SIST participants were simultaneously serving a parole term (Table 5).

When a sex offender is placed on SIST, s/he agrees to abide by specific court-issued conditions, which are usually based upon the recommendations of Parole in consultation with OMH and the designated treatment provider. These conditions mirror specialized conditions imposed on sex offenders subject to traditional parole supervision and often include, but are not limited to, electronic monitoring or global positioning satellite (GPS) tracking, polygraph monitoring, specification of residence, prohibition of contact with identified past or potential victims, a specific set and frequency of treatment sessions, and other related treatment and supervision requirements. Further specifications generally include abiding by curfews and abstaining from drinking alcohol, using illicit drugs, possessing pornography, and using the internet.

Table 5
Respondents Placed on SIST as of October 31, 2008

SIST Activity	Number
Total SIST Orders	39
Active SIST Orders	36
Respondents on Parole and SIST	22
Respondents on SIST Alone	14
Respondents in Community	22
Respondents with a SIST Order – Release Pending	1

Parole is responsible for monitoring individuals on SIST, implementing the supervision plan, and assuring compliance with court-ordered conditions. Sex offenders placed on SIST often participate in multiple treatment programs in the community (see Table 6), and OMH and community treatment providers work closely with Parole to ensure compliance with all SIST conditions. Supervision/treatment team members participate in monthly case management meetings to review the progress of the individual and ensure that any necessary revisions in the supervision/treatment plan are identified and instituted in a timely manner.

Table 6
Treatment Services Utilized by Respondents on SIST Orders

Treatment Services	Percentage Referred and Utilized
Sexual Offender Treatment	100%
Substance Abuse Treatment	46%
Mental Health Treatment	13%
Case Management Services	5%

All sex offender treatment under SIST is based upon a cognitive-behavioral model, and incorporates a relapse prevention component. The treatment team seeks to assist the offender in gaining and maintaining control over criminal sexual behaviors, deviant cognitions and arousal patterns, and other life issues that may contribute to re-offending.

Housing and treatment availability remain significant challenges to SIST plan development. A large portion of counties and municipalities throughout the State have residency restrictions for sex offenders.[24] While such restrictions are intended to improve public safety, research overwhelmingly indicates that residency restrictions neither reduce recidivism nor increase public safety.[25] These findings are not surprising given that unsuitable housing in locations that are remote from social services, employment opportunities, and support systems can interfere with the treatment and supervision of sex offenders. As shown in Table 7, one-third of sex offenders released on SIST resided in hotels/motels and shelters due to the unavailability of more appropriate housing.

Table 7
Type of Residence Utilized by Respondents on SIST Orders

Type of Residence	Percentage Utilized
Housing Program	33%
Shelter	18%
Family Members	15%
Hotel/Motel	15%
Own residence/Apartment	8%
Temporary/Other	8%
Residential Treatment Facility	3%

SIST Violation Process

If a SIST respondent seriously or repeatedly violates the conditions of the SIST order, s/he is taken into custody and a psychiatric evaluation is ordered. As stipulated in SOMTA, once a serious SIST violation has occurred, the psychiatric evaluation must be conducted within five days of the individual being taken into custody. The purpose of the psychiatric evaluation is to determine whether modifications are needed to the SIST conditions or whether the individual is a dangerous sex offender in need of confinement.

Of the 39 individuals subject to a SIST order since the inception of Article 10, 17 have been charged with violating either the SIST order of conditions or the conditions of parole supervision (the latter can occur when individuals are simultaneously serving a parole term and under a SIST order).[26] Two of the 17 violations involved allegations of sexual fondling. These two individuals (and two other SIST violators) were returned to DOCS custody on parole violations, three SIST violators were civilly confined, and the remaining 10 were pending adjudication at the end of the reporting period.

Treatment in OMH Secure Facility

Section 10.10(a) of the MHL authorizes the Office of Mental Health to accept custody and confine respondents in secure treatment facilities, for the purposes of providing care, treatment, and control, following a finding of probable cause. The law states that secure treatment facilities are separate and distinct facilities from psychiatric hospitals (§7.18(b)), and that its residents must be kept separate from other persons in the care, custody, or control of the Commissioner of OMH (§10.10(e)). Currently, OMH operates Sex Offender Treatment Programs (SOTPs) within the secure treatment facilities located on the grounds of CNYPC, and the St. Lawrence Psychiatric Center (SLPC). The CNYPC program has a capacity of 150, while SLPC can accommodate up to 80 residents. In addition the Manhattan Psychiatric Center (MPC) has a 20-bed ward for respondents attending court proceedings in the New York City area. As of October 31, 2008, 131 respondents had been designated to CNYPC and 47 have been designated to SLPC (see Table 8, page 18).

Notes

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

25 See: Duwe, G., Donnay, W., & Tewksbury, R. (2008). Does residential proximity matter? A geographical analysis of sex offense recidivism. *Criminal Justice and Behavior*, 35, 484-504; Nieto, M., Jung, D., & Leno, M. (2006). *The impact of residency restrictions on sex offenders and correctional management practices: A literature review.* Sacramento, CA: California Research Bureau.

26 As of October 31, 2008 there has been a total of 21 SIST violations, by a total of 17 respondents (some respondents have multiple violations).

Table 8
SOTP Census as of October 31, 2008

	CNYPC SOTP	SLPC SOTP	Total
Designations as of 10/31/08	*131*	*47*	*178*
Pre-trial Status	*97*	*25*	*122*
Civilly Confined	*34*	*22*	*56*
Consent Confinement	*26*	*20*	*46*
Trial Verdict	*8*	*2*	*10*

Secure Treatment Programming

As with SIST, the treatment provided in the secure treatment facilities is grounded in cognitive-behavioral therapy and relapse prevention as well as a risk-needs-responsivity approach and the Good Lives Model. Cognitive-behavioral therapy seeks to enable the client to identify and modify errors in thinking and to learn and practice pro-social behaviors. The relapse prevention component enables clients to self-monitor, identify early signs of relapse, and seek the support needed to remain crime-free and productive within both institutional and community settings. Treatment is premised upon a detailed assessment of the individual's sexual pathology, as well as other pathologies, risk factors, learning styles, and strengths or protective factors.

Assessment

A rigorous assessment protocol is utilized in the secure treatment facilities in order to determine the resident's treatment needs. As such, a comprehensive evaluation and assessment is conducted prior to the onset of treatment. The assessment evaluates sexual interest, personality type, reading comprehension, cognitive limitations, substance abuse, psychopathy, treatment progress (if the resident participated in treatment while incarcerated or under parole supervision), and knowledge of treatment. OMH has developed a recommended test battery schedule to be used in its secure treatment facilities.

Five-Phased Treatment

Treatment is structured into five phases, each of which contains several treatment, skill mastery, and psycho-educational modules. Moreover, each phase of treatment has specific goals and measurable outcomes. Progression through the phases of treatment is reviewed by the clinical and administrative staff within each facility. During each treatment phase, various types of assessments are conducted to evaluate the resident's progress in treatment.

Treatment Readiness is Phase I of the treatment program. It focuses on developing the skills needed to successfully participate in treatment. During this phase of treatment, residents are not expected to discuss details of their sexual offending histories. They are expected, however, to admit to having committed a sexual offense, develop familiarity with group processes and their treatment plan, acknowledge wanting to change, and commit to participating in treatment. At the end of Phase I, residents are expected to sign the *Advancement to SOTP Phase II-IV Consent to Participate in Treatment* form, a contract stating that they are willing to participate in psychological testing, including the penile plethysmograph (PPG) and polygraph.

Phase II is *Skills Acquisition and Practice*, in which residents begin to explore their offense history, harm caused to their victims, personal values, sexuality issues, arousal patterns, risk factors, and strategies to live an offense-free life. During this phase, residents are required to participate in the group process, acknowledge their sexual offense history, accept personal responsibility for their

offenses, identify issues related to disordered arousal patterns, and identify their strengths, treatment needs and goals. Moreover, residents in Phase II are required to:

- write and present an offense history and autobiography;
- identify and journal thinking errors;
- demonstrate positive community membership by following the Code of Conduct;
- examine personal values and how they can affect success in the community;
- engage in behaviors that are pro-social, and refrain from secretive, deceptive and manipulative behaviors;
- express emotions appropriately;
- show motivation to change; and
- demonstrate an understanding of how to apply a relapse prevention strategy to one's particular offense pattern.

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

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

Phase V of treatment is *Discharge*. It is during this final phase of treatment that residents are recommended for discharge to the community. This discharge, however, is only recommended after clinical staff and a psychiatric examiner have reviewed the resident's progress and have determined that all treatment goals have been adequately met. A comprehensive release plan is developed prior to release, and it is expected that individuals being released from secure treatment will be transitioned back to the community through SIST. The final decision to approve discharge lies with the court.

Treatment Aids

Treatment for sexual offending can be enhanced through the use of treatment aids such as pharmacologic agents designed to reduce sexual arousal and the PPG, which measures deviant arousal interests.

While most sex offenders can gain control of their deviant sexual arousal and offending behaviors through cognitive restructuring and pro-social skill development, some sex offenders require pharmacologic agents. Consequently, OMH is developing the capacity to provide pharmacologic interventions to augment cognitive-behavioral therapies. Pharmacologic interventions are commonly used in the treatment of sex offenders, particularly in Canada and Europe. SOTP physicians have received specialized training in the prescribing of androgen reduction agents and selective serotonin reuptake inhibitors. As such, an androgen reduction protocol is under development by OMH.

PPG is used in treatment phases II thru IV to measure deviant sexual arousal as well as treatment progress. It is not used to assess for risk of sexual recidivism. If the resident consents to participate in the PPG (a separate consent form is required), the assessment occurs within a laboratory setting in complete privacy.

Special Populations

In order for any behavioral treatment to be effective, it must be tailored to the needs and learning styles of the recipients. For instance, individuals with intellectual limitations or mental illness require specialized treatment programming, as treatment recipients must be capable of understanding and internalizing the treatment lessons. Moreover, the treatment environment must be

perceived as a safe place to learn and practice pro-social skills. Perceptions of safety can be adversely affected by residents with high psychopathy who can be threatening to, and manipulative of, other residents. Thus, OMH has recognized the need to develop more specialized services in order to meet the treatment needs of the diverse SOTP population. OMH is currently developing three specialized treatment tracks for those with serious and persistent mental illness (SPMI), cognitive impairments, and psychopathy.

Annual Reviews

Pursuant to MHL §10.09, the Commissioner of OMH must assure an annual review of whether each SOTP resident remains "a dangerous sex offender requiring confinement." OMH staff has developed a multi-step annual review process that includes notifying the resident of her/his right to petition for discharge, as well as a psychiatric examination. The psychiatric examiner's report is reviewed internally and the Commissioner (or his designee) notifies the court, in writing, as to whether or not the resident is currently a dangerous sex offender requiring confinement. Between November 1, 2007 and October 31. 2008, OMH completed 15 annual reviews which were due prior to or shortly after November 1, 2008.

Part V: Summary of Challenges and Recommendations

Pre-trial Commitments and Low Treatment Participation

As noted earlier, Article 10 requires respondents, for whom probable cause has been found, to be transferred to secure treatment upon release from DOCS, an OMH or OMRDD facility, or parole supervision. As of October 31, 2008, 69% of sex offenders in secure treatment were in pre-trial status. Cumulatively, they had been in secure treatment a total over 45,000 days, at a cost of over $28 million to State taxpayers (or more than $620/day/offender).[27] Approximately 40% of those in pre-trial status had not served their maximum sentence in prison prior to being transferred to secure treatment, but rather had been released from prison at their conditional release date. If these respondents were to remain in DOCS' custody until they complete their entire sentence, there could be significant savings due to the lower cost of incarceration relative to hospital-based treatment.

The placement of pre-trial sex offenders into secure treatment is problematic due to their low participation in treatment programming. Their presence in secure treatment programs is not only disruptive, but, as discussed below, is also extremely expensive. Absent more expeditious adjudication of these cases, the problems presented by pre-trial respondents are likely to persist. Other, less costly, placements are needed to maintain Article 10 respondents during the pendency of their cases.

Census Pressures and Program Costs

As noted above, 178 individuals were designated to a secure treatment facility as of October 31, 2008. The two facilities currently operating have a combined capacity of 230 patients. An additional 20 beds are available in the Manhattan PC for the placement of Article 10 residents who are attending court proceedings in the New York City area. On average, OMH receives 11 designations per month. Thus, it is anticipated that the demand for secure treatment beds will exceed capacity at CNYPC and SLPC by early 2009. At that time, OMH will need to begin operation of the newly constructed Mid-State secure treatment facility that is located adjacent to CNYPC. The Mid-State facility will provide another 150 beds, which will likely be filled by late 2010 given (1) the current rate of Article 10 referrals, (2) average time to disposition, (3) high rates of finding mental abnormality at the trial stage, and (4) limited use of SIST. Although capital construction generally takes three or more years to plan and complete, no new construction is under development. If

Notes

27 These pre-trial respondents include some Harkavy cases that have been hospitalized for up to three years.

patterns of pre- and post-trial commitments to secure treatment remain stable, then the census could reach 600 by 2012.

The costs of SOMTA, as borne by OMH, includes (1) administrative staff at OMH Central Office, which is responsible for Article 10 assessment, referrals, and administrative oversight of SIST and secure treatment, (2) SIST treatment support, and (3) secure treatment facility staff. Central office staffing costs approximate $4.7 million. SIST treatment costs are currently estimated at $42,000 annually, but will increase as more individuals are ordered to SIST.[28] By far the greatest cost of SOMTA for OMH is that associated with secure treatment. The annual cost at an OMH facility, including staff salaries, non-personal service support, and employee fringe benefits, has been budgeted at approximately $225,000/patient. Initially, OMH secure sex offender treatment programs were staffed at a staff/patient ratio of 2.5 to 1, resulting in an annual treatment cost of $22.5 million per 100 residents. OMH is now reconfiguring its staff composition at the SOTPs, as part of the Governor's 2009-10 Executive Budget proposal, to reduce the staff/patient ratio to 1.5 to 1 plus security and support, which will lower the cost to about $175,000/patient, or about $17.5 million per 100 residents.[29] Even at the reduced staffing ratio, the annual value of secure treatment for the projected 600 placements in 2012 could rise to $105 million annually, exclusive of capital construction costs.

The challenge for New York State is to minimize the cost of treating and managing high-risk sex offenders, while maximizing the benefit in terms of public safety. Unfortunately, the experiences of many other states engaged in the civil commitment of sex offenders suggest that, absent careful planning and innovative programming, the civilly committed population could continue to grow unabated with few being released back into the community.[30] The State may be able to stem the growth of this population, however, and improve the cost effectiveness of treatment programming by (1) providing significantly more intensive treatment of high-risk sex offenders while they are incarcerated and (2) developing transitional secure treatment programming in the community to provide residents the opportunity to exhibit success in the community, while still remaining in a residential program.

Intensive Treatment for High-Risk Sex Offenders in DOCS

Clearly, the cost of secure treatment for civilly confined sex offenders is substantial and will continue to grow into the foreseeable future. While the civilly confined population may present grave risks to public safety if released to the community without substantial treatment intervention, it may be efficacious to invest more resources into providing intensive treatment for this very high-risk population while they serve their penal sentences in correctional facilities. As noted earlier in Table 2, sex offenders referred to the OAG for civil management averaged 6.9 years in DOCS prior to their first release on the sentence underlying their Article 10 referral. Of respondents referred to the OAG since April 2008, one-third had not participated in any sex offender treatment while in DOCS.[31] The remaining two-thirds averaged approximately 6 months in DOCS sex offender treatment prior to release. Because DOCS has only recently initiated a longer-term treatment program for sex offenders in need of more treatment, high-risk sex offenders may leave DOCS with more treatment in the coming years. Given the costliness of secure treatment in OMH facilities, it makes economic sense to provide as much treatment as possible to high-risk sex offenders while they're incarcerated and to rely more heavily on the SIST program to manage their risk

Notes

28 The $42,000 estimate is based on an expenditure of $21,000 during the first six months of 08-09 fiscal year.

29 OMH would retain a few wards with staff/patient ratios of 2.0 to 1 to handle residents who are seriously and persistently mentally ill or behaviorally disordered to the degree that they present a danger to themselves or others.

30 In 2005, the Washington State Institute for Public Policy issued a report documenting the number of civil commitments and discharges across 17 states and concluded that 3,493 individuals had been civilly committed since 1990 and only 427 had been released. (See: Lieb, R., & Gookin, K. (2005, March). *Involuntary commitment of sexually violent predators: Comparing state laws*. Olympia, WA:Washington State Institute for Public Policy.)

31 April 2008 was selected as the starting period for this analysis since DOCS treatment programming expanded in recent years.

upon completion of their penal sentence. Additionally, by intensifying and phasing DOCS-based treatment in a manner comparable to that provided in the OMH secure treatment facilities, those respondents for whom civil confinement may still be needed may be able to enter the OMH secure treatment facility at, essentially, Phase III or IV (having completed the early phases in DOCS). This change could significantly reduce the amount of time residents would need to remain in civil confinement prior to transition back into the community. Ultimately, the decision to meaningfully participate in treatment and develop control over deviant arousal patterns lies with the offender. It may be advisable to examine whether the Board of Parole should have greater discretion in the release of recidivist sex offenders who refuse treatment. Thus, the State may need to consider expanding the types of sex crimes eligible to be sentenced to indeterminate life sentences.

Transitional Secure Treatment in the Community

Secure treatment phases II through V require residents to demonstrate an ability to apply the skills learned in treatment and prepare for reintegration back into the community. It is difficult, however, to demonstrate skill acquisition and preparedness for reintegration absent an opportunity to exhibit those skills in a community setting. This conundrum likely contributes to the extremely low release rates experienced by civil commitment programs throughout the country. Arizona is the only state with a high rate of discharge from civil commitment and the director of the program attributes its higher release rate to the State's Less Restrictive Alternative (LRA) community reintegration program. The LRA program provides civilly-committed sex offenders with the opportunity to exhibit lawful behavior in the community while under supervision and residing in a community-based, residential facility.[32] This step-down process has resulted in a three-year average length of stay in civil commitment.[33] Community-based transitional secure treatment also would provide the courts with a placement opportunity that is less intensive than traditional secure treatment, but is more highly supervised than a SIST placement. Lastly, it offers an alternative to traditional secure treatment for SIST violators who need more supervision, but not of the magnitude provided by hospital-based secure treatment.

Community-based correctional facilities could offer the type of secure community residences needed to reintegrate civilly committed sex offenders back into the community. Placement in such facilities would afford residents the opportunity to exhibit success in the community, while still maintaining significant supervision and control over that population.

Conclusion

SOMTA provided the State with the authority to civilly manage sex offenders who suffer from a mental abnormality that predisposes them to commit sexual offenses and results in their having serious difficulty in controlling that criminal behavior. Unlike legislation enacted in other states, SOMTA offered two levels of civil management, one directly to the community through the SIST program and a second in a secure treatment facility operated by OMH. Clearly, the intent of SOMTA was for secure treatment to be utilized in those extreme cases in which the offender could not be managed in the community under intensive supervision and treatment. At the time SOMTA was enacted, budget projections assumed a secure confinement to SIST ratio of 1:2.5. The inverse has occurred, however, with 178 designated to secure treatment by the close of October 2008 and only 36 in the community under a SIST order. Moreover, 17 of the 36 on SIST were pending violation on either SIST conditions or conditions of their Parole su-

Notes

32 Information provided in an 11/25/08 e-mail from Daniel Montaldi, Director Arizona Community Protection and Treatment Center.

33 Ibid.

pervision. The dynamics underlying the unanticipated growth in the secure treatment population are many, including lengthy periods of pre-trial placement in secure treatment (most respondents are in pre-trial status), an early implementation trend in respondents consenting to confinement, and the high rate at which juries find mental abnormality and courts find that respondents with mental abnormalities are too dangerous to be safely managed in the community. Cumulatively, these dynamics have resulted in the growth of secure treatment at a rate over 100 per year. Absent changes in external circumstances, this pattern will likely continue into the foreseeable future. Moreover, if rates of release from secure treatment in New York State mimic the extremely low release rates of nearly all other civil commitment states, the population growth will continue unabated for many years and at costs that may well be unsustainable in an uncertain fiscal climate.

While civil confinement is an important tool to have available when other means of control have proved ineffective, much more can be done to reduce the need for and length of civil confinement in New York State. Most notably, the State could consider (1) increasing the intensity and duration of treatment of high-risk sex offenders while they are serving their penal sentence in DOCS, (2) enhancing safe housing options for sex offenders seeking to return to the community by controlling residency restrictions and providing supervised housing programs, and (3) developing community-based secure treatment programs that could facilitate the transition of civilly confined sex offenders back into the community and provide enhanced housing options for SIST violators or other sex offenders in need of more supervision than the SIST program can provide. Absent such innovation, the State will bear the enormous fiscal burden of an ever-growing civil confinement population.

New York State
omh
Office of Mental Health

January 2009

APPENDIX

Table 1-A
SOMTA Qualifying Offenses

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

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

Table 1-B
SOMTA Qualifying Offenses

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

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

* Sexual Motivation may be present if:
a) Instant Offense includes behavior that could have resulted in a sex charge, but did not.
b) Instant Offense includes a sex offense charge where a plea was taken to a non-sex offense charge in satisfaction of the sex crime charge
c) Offender made statements of intent of a sexual nature to the victim of the instant offense
d) Instant Offense is indicative of prior modus operandi resulting in a sexual offense conviction
e) Documented admission of the offender to the instant offense being sexually motivated