MEETING

of

THE JOINT LEGISLATIVE TASK FORCE TO STUDY THE ADULT DIAGNOSTIC AND TREATMENT CENTER

"Testimony from superintendent and treatment staff"

LOCATION: Adult Diagnostic and Treatment Center
Avenel, New Jersey

DATE: November 1, 1994
10:00 a.m.

MEMBERS OF TASK FORCE PRESENT:

SENATE:

Senator C. Louis Bassano, Chairman
Senator Peter F. Inverso
Senator John A. Matheussen
Senator John A. Girgenti
Senator James E. McGreevey

GENERAL ASSEMBLY:

Assemblyman Stephen A. Mikulak, Chairman
Assemblywoman Marion Crecco
Assemblyman James W. Holzapfel
Assemblyman Joseph R. Malone, III
Assemblywoman Shirley K. Turner
Assemblyman Charles "Ken" Zisa

Gregory Muller
William H. Thomas
David Evans, Esq.
Professor Alexander D. Brooks

ALSO PRESENT:

Anne M. Stefane
Office of Legislative Services
Aide, The Joint Legislative Task Force to Study the Adult Diagnostic and Treatment Center

Hearing Recorded and Transcribed by
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New Jersey State Legislature

THE JOINT LEGISLATIVE TASK FORCE TO STUDY THE ADULT DIAGNOSTIC AND TREATMENT CENTER

LEGISLATIVE OFFICE BUILDING, CN-068
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MEETING NOTICE

TO: MEMBERS OF THE JOINT LEGISLATIVE TASK FORCE TO STUDY THE ADULT DIAGNOSTIC AND TREATMENT CENTER

FROM: SENATOR C. LOUIS BASSANO, CHAIRMAN
ASSEMBLYMAN STEPHEN A. MIKULAK, CHAIRMAN

SUBJECT: **TASK FORCE MEETING - November 1, 1994**

Comments and questions may be addressed to Anne M. Stefane, Task Force Aide, or make scheduling inquiries to Kathleen Espieg, secretary, at (609) 984-0231.

The Joint Legislative Task Force to Study the Adult Diagnostic and Treatment Center will meet on **Tuesday, November 1, 1994 at 10:00 AM at the Adult Diagnostic and Treatment Center, Avenel, New Jersey.**

The task force will tour the center beginning at 10:00 AM. Following lunch, the task force will receive testimony from the superintendent and treatment staff.

The tour will be open only to members of the task force, invited members of the press and legislative staff. The meeting will be open only to members of the task force, legislative staff and members of the press. The Office of Legislative Services will record the meeting and transcripts will be made available to the public at a later date.

Issued 10/28/94

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SENATOR C. LOUIS BASSANO (Senate Chairman): May I please call the meeting to order? Will everyone please try to find a seat so we can get started? We will start our meeting today by asking Anne Stefane, of Legislative Services, to do a roll call of the members of the Task Force so we can see who's here.

MS. STEFANE (Task Force Aide): Mr. Muller?

MR. MULLER: Here.

MS. STEFANE: Mr. Thomas?

MR. THOMAS: Here.

MS. STEFANE: Assemblyman Zisa?

ASSEMBLYMAN ZISA: Here.

MS. STEFANE: Assemblywoman Turner?

ASSEMBLYWOMAN TURNER: Here.

MS. STEFANE: Assemblyman Holzapfel?

ASSEMBLYMAN HOLZAPFEL: Here.

MS. STEFANE: Assemblyman Malone?

ASSEMBLYMAN MALONE: Here.

MS. STEFANE: Assemblywoman Crecco?

ASSEMBLYWOMAN CRECCO: Here.

MS. STEFANE: Assemblyman Mikulak?

ASSEMBLYMAN STEPHEN A. MIKULAK (Assembly Chairman): Here.

MS. STEFANE: Senator Girgenti?

SENATOR GIRGENTI: Here.

MS. STEFANE: Senator Matheussen?

SENATOR MATHEUSSEN: Here.

MS. STEFANE: Senator Inverso?

SENATOR INVERSO: Here.

MS. STEFANE: Senator Bassano?

SENATOR BASSANO: Here.

MS. STEFANE: We have a quorum.

SENATOR BASSANO: Thank you.

I would like to thank the members of the Task Force and the staff at the Center for taking the time to join us today.

As most of you are aware, the Task Force was established by our legislative leaders to study the effectiveness of the Treatment and Rehabilitation Program here at Avenel. While recent tragedies have served to put a spotlight on activities at the Center, I want to make it perfectly clear that we are here to evaluate the Program, and not to find someone to blame for the unfortunate situations that have occurred.

The Task Force has a twofold purpose. The public demands, and rightly so, that we do everything in our power to ensure the safety of every man, woman, and child who lives in this State. To accomplish that, we must conduct a thorough review of the Avenel Program from the inside out, so to speak, to determine whether we are doing everything possible to provide those incarcerated at Avenel with the kind of treatment that will prevent a repeat of the horrific tragedies that have scarred our society during the past few months. Let me stress that if we, on this panel, deem that changes are necessary, we will make recommendations to the Department of Corrections, to the Legislature, and to the Governor.

Today, we will be hearing from the administrators at the facility, and learning about the kinds of programs that are available in the criteria, participation, and release. At future hearings, we may talk with some of the inmates or some of the other employees. If necessary, we will bring in experts in psychology and criminology who might help us with our evaluation.

While I do not want to make any promises regarding the results of our review, I will guarantee that we will pursue every avenue available to us. No one in this room wants a repetition of what has occurred in Hamilton Township, Passaic, Manalapan, or Asbury Park. If this Task Force can change just one thing to accomplish that, I can assure you that we will.

One more thing: I have invited editors and the press here today, because their focus on this issue has been intense over the past few months and, indeed, has contributed to the package of legislation that was signed into law yesterday. I hope the members of the media will continue to pay attention and will support our efforts, as we undertake this study.

I would now like to turn the microphone over to my counterpart, Assemblyman Mikulak.

ASSEMBLYMAN MIKULAK: Thank you, Senator Bassano.

The fundamental mission of this Task Force, in my opinion, is to determine whether pathological sex offenders can, indeed, be treated as patients, which is the theory on which Avenel is constructed, or whether they should be treated as just any other dangerous criminal. To answer such broad questions is an ambitious mission, but it is central to the issue of sex crimes. After all, many people are clearly skeptical of the theory that people like Jesse Timmendequas was sick in a mental sense. Still more people believe the question is irrelevant, since the answer cannot make your neighborhoods any safer. At the very least, there is reason to question whether some of the so-called treatment methods advanced here at Avenel have scientific value.

In order to answer these broad questions, however, we must first answer the narrow ones, such as:

What is Avenel's actual statistical success rate for treating sex offenders?

Which treatments seem to work, and which ones don't?

What alternatives are there for offenders who cannot be treated?

How do other states handle sex offenders?

Can the State do anything to help Avenel do a better job?

Can Avenel be doing anything differently?

Answering these questions clearly and honestly will be the job of this Task Force. We will not be satisfied until the job is finished. Every parent in the State deserves to know whether sex offenders are measurably less dangerous when they come out of Avenel than when they go in.

Now, just in the last three weeks since this Task Force was impanelled, two more graduates of this facility have made the headlines. This seems to be occurring with terrifying frequency, so we are here to get some answers today.

SENATOR BASSANO: Thank you.

The first person the Task Force will entertain will be Superintendent Bill Plantier, who took us around on a tour earlier today. Superintendent, please sit down.

W I L L I A M F. P L A N T I E R: Thank you.

SENATOR BASSANO: In light of the fact that we are going to be hearing from Mr. Sager, would you feel more comfortable if both of you testified at the same time?

MR. PLANTIER: I think it probably might be best, because Mr. Sager certainly has some questions that he can answer that I am not quite familiar with.

SENATOR BASSANO: Would you like to open with a statement?

MR. PLANTIER: Certainly just a very brief one, if I may.

Certainly, the institution has said in the past, and we certainly want to say it publicly here now, that we welcome the Joint Task Force inquiry into the institution, and certainly we hope to be able to answer all your questions to the best of our ability. We will certainly be forthcoming in terms of what we see as needs for the facility in the future.

Thank you.

W A Y N E S A G E R: Do you think it would be helpful for me to give a general description -- a very quick

general description -- of the Program and therapeutic aims, at this point?

SENATOR BASSANO: Sure, if you would like to.

MR. SAGER: Then, in very general terms, the three things that we try to address therapeutically in treatment of the sex offender are:

Number one, and probably most important, responsibility. In other words, does the sex offender, at all, have a sense of responsibility for what he did? Does he have any feeling for the victim of the sex offense he committed? Without that, it is virtually impossible to get any form of therapeutic alliance between the therapist and the client, because we are not on the same page. The offender has to be motivated to change his behavior, and usually the offender is motivated in ways that the normal person would be motivated not to commit a sex offense; that is, an understanding that the sex offense would have a negative effect on the victim.

The reason why this is so important, and the reason why I mention it first, is because I think any therapist would tell you that there are certain people who never gain that sense of responsibility when they are in therapy. If they never gain that sense of responsibility, there is little chance that any change will take place in them through therapy, regardless of the therapeutic modality.

The idea that there is a sense of responsibility, there is a sense that the person feels responsible for what he did, and the idea that what he did was harmful to the other person, is extremely important, and is the first thing that needs to be established in therapy.

The second thing that sex offenders appear to have serious problems with is interpersonal issues. They have never been married or they have had serious problems with their marriages. They will again and again go into relationships where there are serious problems, and it is an area of therapy

that has to be addressed with them. Rapists, often, are extremely angry people. Child molesters are extremely immature people. Those things must be addressed from a therapeutic standpoint in order for progress to be made.

The third general area is sexual arousal patterns. Often, sex offenders have a deviant arousal pattern that is very difficult to treat, very difficult to handle. A sex offender might be aroused by prepubescent females, and it might take a long time for us to do any kind of work in that area in order to change that arousal pattern.

I just wanted to give you an idea of the general problem areas we find that sex offenders have specifically, that maybe other people who come to a psychologist do not have, and the specific areas that we try to address from a therapeutic standpoint.

Upon that, we might be able to draw some questions and talk more about our therapy here.

SENATOR BASSANO: Let me start the questions, then, by asking: How many people max out of this facility; that is, serve out their full term and then leave?

MR. PLANTIER: Approximately 90 percent, at present.

SENATOR BASSANO: So the statement you made earlier that some of these people never gain a sense of responsibility could very well fit a lot of that 90 percent pattern that is leaving here; that many of those people you maybe never even got to during the time that they were incarcerated, but the fact that their term is expired, they are walking out the door now. Is that correct?

MR. SAGER: I wouldn't say that the entire 90 percent are in that category. I would say that--

SENATOR BASSANO: But there is a great number?

MR. SAGER: --there is a percentage of people in that category that never showed any kind of understanding for the seriousness of their offense. There are other people who do

show that and have made quite a bit of progress, but our release process is a very conservative one. We want to make pretty sure that the people who get out of here on parole supervision are not dangerous people at the point where we let them go. So because of the conservatism of that release decision, there are people who have made quite a bit of progress, but not as much as we feel is absolutely necessary for them to gain release.

SENATOR BASSANO: Let me say to you that I am not that concerned about the person who makes parole, because that person is proving to somebody that whatever problems he has are under control, to the point where someone has recommended that he leave this institution early. My concern is the people who are maxing out who are using this as a penal institution, and nothing more. That is why I am going to ask the next question: Would we be better off if we changed the system to allow judges to sentence people here for an indeterminate amount of time, so the only way they are going to leave here is through parole? If that person is not ready for parole in five or ten years, he will continue to serve. Would society be better served, in your opinion as people who work in a penal institution, with a change of that type?

MR. PLANTIER: I would say, certainly, that when we had that type of indeterminate sentencing prior to the new penal code being enacted in 1979, the bulk of the population in this facility -- however, it was a much smaller facility than we are talking about now -- had very, very long sentences, and them, being indeterminate sentences, earned absolutely no time off of them.

There was a very good motivator that accompanied that 30-year indeterminate sentence, which was a 30-year, day-for-day sentence, to do therapy and get released through parole. We also had sentences that were much shorter, but a

lot of them were in the 12-, 15-, 30-year range. So it certainly proved to be a good motivator to do therapy.

While most sentences were increased with the enactment of the 2C penal code, sex offenders' in this institution -- repetitive, compulsive sex offenders' -- actual sentences actually went down. So from 30 years, many of them went down to the 10- to 15-year range. Now, when you add credits onto those sentencings, certainly you are talking about individuals or inmates who are doing a significantly less period of time for a crime than they would have prior to 1979.

Would it be a motivator for all of them? That is hard to say. There are many things we could use as motivators, and, obviously, indeterminate was one of the things we used back then. I don't know if it would work in all cases. I certainly see it as one way to motivate them. I also see that the latest law being enacted, where we can take away credits from those people who do not fully participate in the Program-- I also see that as being a good motivator.

The bottom line is, I would assume that we have some responsibility to try to motivate them, but the person who is going to do extremely well and who is going to make it, is really the person who is going to be self-motivated. I think what you really have to strive for is to get people who have enough wherewithal and have enough disgust about the behaviors they have created to really want to help themselves. That is the best type of motivation. But, unfortunately, that is not there in all cases.

SENATOR BASSANO: Would we be better off if we had a system whereby the people who were housed here, if they were not responding to treatment, or refused treatment -- if we gave authority to you, as the Superintendent, to work with the Department of Corrections to move them into another facility, thereby freeing some of the beds for people who should be getting treatment? I bring that out to you because, earlier,

during the tour, someone asked the question, "How many people are taking therapy?" I think the figure of 90 percent was stated, which means that about 10 percent are not receiving treatment.

MR. PLANTIER: There are a couple of dangers to that. In the past, we have tried that, where we cleared out people who just weren't doing therapy so we could get rid of some of the deadwood, and also, obviously, their negative influences on the population, the bulk of whom were doing therapy. So we did move them out at one time. Unfortunately, what happened was, during that current set of laws and parole procedures, those guys ended up getting paroled much more quickly, actually ended up getting paroled out of the regular penal institutions. Even though that wasn't so well-borne-out statistically, the perception among the population was that they would get out much quicker if they were transferred to a regular State prison. What we had happening-- It became a self-fulfilling prophecy. For every one therapy refusal we moved out, we had another therapy refusal begin in here, simply because they wanted us to continue to move them out so that they would do less time and get out more quickly.

SENATOR BASSANO: Let me give you what I envision, and that would be if a person is sentenced for a sex crime, where he possibly would be sentenced to Rahway or Trenton for a period of time, once he fulfilled that term for the crime he committed, he would then be sent over here. This would be the privileged place to be, not there, and the only way you would get out of the system -- the only way, is through your front doors, through parole.

You are saying to me that what happened in the past would stop if we changed the system the way I envision it?

MR. PLANTIER: If you changed it around, yes.

SENATOR BASSANO: Do you agree that that may be more workable?

MR. PLANTIER: Certainly, more workable, and there certainly have been discussions in the past. Now, I have no figures to indicate how this may impact on the Department overall, because you are talking about a significant change in the number of people and where they go. That, I think, needs to be researched. But in terms of having them serve the punitive aspect of their sentence prior to coming to Avenel for treatment, that is certainly something we have kicked around for a long time. I certainly think there is a great deal of support for that, in a general sense, yes. Certainly, there are punitive aspects to these sentences. Maybe a better place to put them for that period of time would be in another facility. So we certainly see that as a workable proposition, if some of the other areas could be worked out.

MR. SAGER: May I add just one thing to that?

SENATOR BASSANO: Please.

MR. SAGER: From a therapeutic standpoint, I would just like to point out that sometimes it takes upwards of five years, sometimes longer, before we would feel comfortable, even if someone is doing good work in therapy. So if that were the case, I think it should be set up in a way that we would have at least that amount of time to be able to work with the person before there would be any kind of parole consideration. But as you say, if they are here for as long as it takes for them to pass parolability, then that does sound like a good idea to me, also.

SENATOR BASSANO: If we are giving you people the authority to say that they are not responding, or they are refusing, and you are going to send them back, the only way they are going to get out is to come back through the system again to get back in here. So there is a major motivation to try to get therapy and try to pass whatever board you have made up of psychiatrists that will stamp on someone's paper that they feel he can function in our society.

Tell us about the programs that you have here. Tell us about what you do with these people.

MR. SAGER: Okay. When we first started our Program here in 1976, when the building first went up--

SENATOR BASSANO: Just let me stop you for one second. I hate to interrupt you, but I have been asking a lot of questions. There are a lot of members here. Please, if you have questions, raise your hand and feel free to get involved in the discussion.

MR. MULLER: I would like to ask one question.

SENATOR BASSANO: Before you go, please take his question, okay?

MR. MULLER: The first thing we spoke about was that the resident here must be willing to accept responsibility for his actions before you can help him in any way. Now, if he will not accept that responsibility, why would we keep him for a longer period? I mean, you know, give them a certain amount of time, but why overburden this facility with someone where you know it is not going to work, or you are pretty damned sure it is not going to work. You must know that.

MR. SAGER: Administratively, you might have one answer; therapeutically, you might have another. From a therapeutic standpoint, I would agree with you 100 percent. If you are a therapist and you are running a group of sex offenders, the biggest pain in the neck you have is that people will sit there and not be willing to tell you about their problems, or be willing to work with you. If we could cut the deadwood in that area, it would help us from a therapeutic standpoint. There is no doubt about it.

MR. MULLER: May I say one other thing? As you can see, I have been around for a long while. When I saw a therapy class with probably 20 people in it downstairs today, half of them were lounging around on pillows. I mean, wouldn't it be better if we had a sense of discipline? I mean, you are going

to be there yourself to listen. I mean, you can't have one man sitting there talking to a camera, and the others lounging around on the floor, you know, half asleep and all this.

I have said what I wanted to say for now.

ASSEMBLYMAN MIKULAK: We have read accounts of the therapy that was practiced here called "aversion" therapy, or "masturbation satiation." Could you explain that to us?

MR. SAGER: Okay. Masturbation satiation is a particular form of behavior therapy that is used sometimes for people who have deviant sexual arousal patterns. What is behind that is having someone masturbate to orgasm to a deviant sexual fantasy. After orgasm, continue to masturbate using boredom as a negative arousal pattern, so that that is paired with the deviant arousal pattern in a way to make the deviant arousal pattern less enjoyable for the person. That is one of a number of about six or seven different behavioral programs that could be used that could help deviate arousal pattern.

I have not used that particular one myself in here. I don't know how much it is being used by other therapists. I don't think it is being used too much in here, but it is a procedure that is written up in the literature and it is fairly widely accepted throughout the country as a way to deal with this problem.

ASSEMBLYMAN MIKULAK: But it was being used, because people from the Department of Corrections told me it was discontinued here a number of years ago, and is not now being used here.

MR. SAGER: Mastubatory satiation. I believe it is still being used when the need presents itself.

ASSEMBLYMAN MIKULAK: Thank you.

Now, just based on newspaper articles-- I read a newspaper article that said, "One of the therapists has a bachelor's in theater arts. Would you explain?

MR. PLANTIER: All the psychologists in the institution, as well as all of the staff, professional and otherwise, are all Civil Service approved. The Department of Personnel has approved their credentials. That includes the psychologist of which you speak. She has a degree in theater arts. I believe it is a master's. When the Department of Personnel approves people, they also look at the core curriculums and the course work they have taken. That particular psychologist came to us already functioning as a psychologist. She was a transfer; she came to us from the Woodbridge Developmental Center, where she had worked for many years. She certainly was certified with her course work by the State of New Jersey, by the Department of Personnel, and by the Department of Corrections, prior to her employment.

MR. SAGER: May I add something to that?

SENATOR BASSANO: Sure.

MR. SAGER: The Department of Personnel just put the particular individual we are talking about on a senior psychologist employment list, which means that her credentials have been recently reviewed and have been found to be even more substantial than the entry level position she was in to begin with.

Another thing, if I may: I researched certification laws in other states, states that have certification laws for people working with sex offenders. In each case, the certification was less -- the criteria for certification was less than what we ask for as entrance level psychologists here. So our entrance criteria actually are quite high compared to other states and other programs.

ASSEMBLYMAN MIKULAK: That explains something, when you see it out of context, okay?

For Mr. Plantier: There was an event that took place before you were Superintendent where three business officials from the State Department of Corrections in this institution

were charged with obtaining more than $10,000 worth of clothing from a Carteret men's store and billing the State. There were some indictments. I think it involved misuse of prisoner accounts, inmate accounts.

MR. PLANTIER: I believe the indictment included inmate welfare accounts.

ASSEMBLYMAN MIKULAK: Okay. What steps have you taken since then to make sure that this practice doesn't, you know--

MR. PLANTIER: Obviously, those individuals are no longer employed here. We have a new business manager who has undertaken new steps to ensure internal controls. We have just been audited again by the Department of Corrections in the past year, and there were no major decrepancies found. I would find that to be, like, a one-time event, a very unfortunate event, but I don't think it was in any way indicative of how the institution functioned from a business office perspective.

ASSEMBLYMAN MIKULAK: But you have instituted procedures that will ensure that that will not happen, has not happened, cannot happen again?

MR. PLANTIER: Part of the problem-- I will be brief, but part of the problem existed when there was an intermingling of funds between inmate welfare funds and State accounts. We have certainly taken steps to ensure that there will be no intermingling of inmate welfare funds and State accounts in the future. That was a great problem, actually.

ASSEMBLYMAN MIKULAK: Okay. Thank you.

SENATOR BASSANO: John -- Senator Girgenti?

SENATOR GIRGENTI: Either Mr. Sager or the Superintendent: Do you keep records of the recidivism rate?

MR. SAGER: Most recently, we have had personnel problems in terms of enough clinical workers to handle the caseload we have in our institution. We did assign one of our therapists as Director of Research, but shortly after assigning that person, we lost a few psychologists. The positions were

frozen. Although we wanted to give that person a half caseload so that she could determine the recidivism rate right up to the present time, we had to use her as a full-time clinical therapist, because of the need we had just to fill caseloads. We had to make an administrative decision that we needed to cover the caseload before we could do the recidivism research. So, unfortunately, the latest recidivism study we have to show you is from 1991, which was done by Trenton State College, Dr. Walsh, and his students at Trenton State College. That study found an 18 percent arrest rate of 170 offenders who were released from 1985 to 1988; 31 of 170, or an 18 percent rearrest rate. Eleven of the 170 were arrested for another sex offense, or 6 percent. That was the latest study we had.

We did an in-house survey for inmates released from 1976 to 1988, which found that 61 of 266 inmates were rearrested, which is a 23 percent recidivism rate, and 47 of the 266, or 17 percent, were arrested for new sex offenses. That, I might point out, was a 12-year study, which included people who had left this institution and were out in the community for upwards of 10 years, sometimes 12 years. One thing I think is important to point out with recidivism, in fairness to us, is that the field now does not talk in terms of cure. In other words, if we have someone in a sex offender program, we want to set them up and put them in a situation where we can maintain them safely when they are back in the community, meaning continued treatment, continued supervision.

What we had, in a lot of these cases, a lot of the recidivists was, they would leave this Program. They would go out in the community, and they would not receive any further treatment. After a man is out in the community for three years, five years, we don't feel like we really can be held responsible for that person's behavior, if we were to tell that person that he needed to continue treatment and then he did not

continue treatment. I wanted to say that on the heels of the recidivism study.

There was also one other recidivism study that we have on our records that was done by Mr. Prendergast, who was here as Director of Professional Services in 1978. His statistics show a 9 percent recidivism rate for new sex offenses, and an 11 percent rate for nonsex offense recidivism. These numbers are consistent with other programs throughout the country and appear to be consistently lower than rates where sex offenders are studied who have not received treatment.

SENATOR GIRGENTI: That was the second half of the question I was thinking of. How does this compare-- How does this Program here compare to national statistics in terms of recidivism? Now, you're saying it is a '78 survey you're talking about.

MR. SAGER: I mentioned three surveys altogether.

SENATOR GIRGENTI: No, but I mean the one-- The last one you mentioned was from 1978?

MR. SAGER: The last one I mentioned was published in 1978.

SENATOR GIRGENTI: So can we compare this to our national statistics? Is there any way of--

MR. SAGER: It is difficult to compare for one main reason: The men we have at Avenel have been judged to be repetitive, compulsive sex offenders. That means that they have already committed more than one sex offense before, and are found to be compulsive, which means they are found to have a relatively serious problem. In order for us to compare our statistics fairly with another state's statistics, that other state would have had to take people with problems that were as severe as the people's problems we had in our Program.

What the New Jersey law calls for is for us to take people who appear to have a serious problem, regardless of how serious that is, and regardless of their treatability. There

are many other programs in the country that take people who want treatment, who are obviously motivated for treatment, and who do not have serious violent offenses in their backgrounds. We do not have that luxury in New Jersey. We willingly take everyone who is found to have a serious problem. So, although our recidivism rate looks good and is comparable to other recidivism rates throughout the country, we feel it is even more meaningful because we take as many people and as serious problem people as we do take.

SENATOR GIRGENTI: What are the hallmarks of success? How do you know someone is getting better, for instance, in this type of Program, with this behavior?

MR. SAGER: I think it would be fair to say that we handle that on an individual basis by looking at the precursors for a person's problem behavior. Sex offenders are individual. They have some problems that are very similar to each other, but also some problems that are individual unto themselves. I think the three things I mentioned before probably are a good place to begin: If they begin to show responsibility for what they did; if they begin to show empathy for the victim; if they begin to show a higher maturity level in their interactions throughout the institution. Remember, we have these guys here 24 hours a day. We see them day in and day out in all different types of situations. That is one of the positive things to happen -- people in an institution. We can see them. We can get feedback from officers, recreational staff, etc. We have a really good way of knowing how they act and what their behavior is like, and if their behavior is improving or not.

Another thing we look at and make determinations on is their insight level. Do they really know what went on in their life? Do they know what pushed them to begin to commit sex offenses? If they can convince us of these things, then we

begin to feel that we are making progress with them therapeutically.

SENATOR GIRGENTI: One more thing: I read somewhere, I think in a brief overview we received, that the ratio is 47 inmates to 1 therapist. Is that acceptable in terms of professional standards? Is this a doable situation? Maybe you can embellish on that a little bit.

MR. SAGER: I think that is quite high. I would hate to see it go any higher, number one, and I would love to see it go lower. Just lately, we have been given permission, through the Central Office, to hire five additional psychologists. That is going to help us out a lot. At this point, we are not at 47, we are at 44, but it is still at the point now where we really feel as though we are treading water. We feel that if we could bring that number down to 33 or 35, we would feel much more comfortable. Our groups would be smaller. The waiting lists for ancillary groups would be smaller, and we would be able to do much more individual therapy than we are able to do now. We think all of those things are extremely important to our effectiveness.

SENATOR GIRGENTI: Just one final question: What are the criteria you use to decide if someone can resume his life in society? Would it be basically the same as you said before in terms of motivational--

MR. SAGER: I think those are the basic areas we look for. Again, we look on an individual basis. We see exactly what was going on in that person's life, and we try to deal with that. I might point out that our release process consists not only of our in-house staff determining if someone is ready for release, but we also have a special Classification Review Board, which is a group of outside psychologists independent of this institution, who come in and make an evaluation on top of our evaluation.

SENATOR GIRGENTI: Do you feel, just as a follow-up--I know we suggested, and I know we passed yesterday, lifetime supervision, you know, to continue to have counseling and so forth. Do you feel that is important, that we should continue that contact, that accountability, control, or whatever you want to call it?

MR. SAGER: I think one of the biggest holes in our program, up to this point, is the fact that we offer intensive therapy for these guys up to the point where they reach their maximum date, and then the front door swings open and they are back out in the community. I would say that probably the majority of those people we never see again. So the idea of having lifetime supervision where we could get involved, we could offer after-care services to them, and we could interface off them with parole people who are supervising them, is probably the best thing we could do at this point. That, by the way, is written up in the literature.

One of the things that appears to be most effective in lowering recidivism rates more than anything else, at this point, is a situation where there is a Relapse Prevention Program. Teach the man what relapse is all about; what the lapses might be; what might come before a relapse; what is a precursor to negative types of behavior. Also, teach the man's family what these precursors are. Teach the parole officer what the precursors are, and work on that type of thing in our after-care therapy program. If we could set up a situation where we are on top of these people for years and years after they get out of here, I think we would be creating a safer environment.

SENATOR BASSANO: I envision us looking at the community support system, particularly if we go to a mode where most of the people leaving here will go out on parole. Then you could mandate that type of system, and have it strategically located in major areas throughout the State, so

that we could continue to provide help to these people once they leave your institution.

I have one fast question, though, and it is on the Program you are administering now. Can you tell me what you are basing your Program on? Is there a model out there that you are following? Is there a guide out there that you are following -- a national guide, a recommendation, if you will, as to the treatment of the prisoners?

MR. SAGER: Some of the literature that we are leaving out here for people to take, if they want to take it, suggests what the national trends are in treating sex offenders. What is mentioned again and again in this report is the cognitive behavior style of therapy. What that means is that you deal both with the thinking level of the individual and the behavior level of the individual as you determine which therapeutic intervention to employ.

Some of the specific groups you use in the cognitive behavioral model are: the relapse prevention model, social skills training, anger management, and victim empathy. Those are the types of programs that have been found, over the past five years, or ten years, to lower recidivism more than any other types of programs. So that is what we are focusing on right now. A great deal of our Program, all of our ancillary groups, are aimed toward that particular way of treating somebody.

That is not the only thing we use. We still use our primary therapy groups to deal with the person in his totality. So, in addition to using narrowly focused groups, we also use general types of groups, just to try to make sure that we cover all the bases. We are a conservative program, and we want to make sure that we are doing everything we can for the men.

SENATOR BASSANO: Is there a particular institution whose model you follow?

MR. SAGER: Any particular other institution?

SENATOR BASSANO: Yes.

MR. SAGER: Probably the institution we follow most closely is the institution in Vermont.

ASSEMBLYMAN MIKULAK: To what extent do you use drugs, and in what capacity? Do you use psychotropic drugs for behavior control or modification, or a sexual depressant type of drug?

MR. SAGER: We use psychotropic medications in the institution for traditional psychiatric problems. We use Depo-Provera and other types of drugs that are used to modify sexual arousal patterns much less in the institution, because in the institution these men do not present a danger of recommitting. If we were to start more intensive therapy in the community with men who continue to have the deviant arousal pattern, we would use this type of medication much more often, and we would use it in conjunction with psychiatrists who, of course, are trained and licensed to use this medication.

ASSEMBLYMAN MIKULAK: That's called chemical castration?

MR. SAGER: One term is chemical castration. We are in the stage now where we are learning more and more about these things. They are starting to learn about agents that actually have an action on deviant arousal patterns, and not so much of an action on the more traditional arousal patterns. Some people are hoping that that is the wave of the future, but these things are relatively new, at this point.

ASSEMBLYMAN MIKULAK: Thank you.

SENATOR BASSANO: Assemblyman Holzapfel?

ASSEMBLYMAN HOLZAPFEL: In other words, the system, as it works in New Jersey, is that all sex offenders, excluding certain types of offenses, are sent here for evaluation. Correct?

MR. SAGER: All first, second, and third degree sexual assault charges are sent here for evaluation.

ASSEMBLYMAN HOLZAPFEL: Basically the contact offenses around aggravated contact.

MR. SAGER: The more invasive contact are the people that we would handle; less invasive, they would not come through our system.

ASSEMBLYMAN HOLZAPFEL: Do you have a handle on how many of those come in here in a year?

MR. SAGER: I think maybe Mr. Plantier probably has a better handle.

MR. PLANTIER: How many evaluations do we do a year?

ASSEMBLYMAN HOLZAPFEL: Yes. In other words, these are people who have been convicted of a sexual offense.

MR. PLANTIER: We do about 550 of them a year -- sex offenses.

ASSEMBLYMAN HOLZAPFEL: Out of that 550, can you approximate how many are found -- as far as the judge is concerned after your recommendation--

MR. PLANTIER: For many years, the number ran between 20 percent and 30 percent in any given year. This year, for some reason -- we are not exactly sure why yet -- the number for the last several months has been running well over 40 percent. It is not long enough into the process to know if this is going to be a continuing trend, but we are looking at it and we are concerned that the number has gone up that high.

ASSEMBLYMAN HOLZAPFEL: Now, if I take your number, that would mean that 60 percent are being sentenced to State prisons.

MR. PLANTIER: Or are being placed on probation or adjudicated in some other manner.

ASSEMBLYMAN HOLZAPFEL: But they are either in another facility or they are somewhere-- They are not here, are they?

MR. PLANTIER: They are not here.

ASSEMBLYMAN HOLZAPFEL: Now, I don't mean to question Mr. Sager as far as his statistics on recidivism are concerned, but as I read these reports, depending upon what year you are talking about -- and some of the numbers are somewhat different from what you said-- Even the report itself is somewhat self-critical on that. It was not done for a very long period of time. As far as the recidivism rate, we know that sex offenders have caused quite-- Usually the length of time is important with a sex offender, as far as recidivism.

MR. PLANTIER: It's rampant.

ASSEMBLYMAN HOLZAPFEL: Do we have any information as to how the people are doing next door in Rahway, let's say, who are convicted sex offenders, but are not found to be compulsive on the part of your staff? They are sentenced there by a judge, and then are either maxed out, as apparently most of the people here are, and are out on the street. Do we know what the recidivism rate is for those types of individuals who have not received-- Maybe I am presupposing that they do not receive any special treatment next door. Do you know whether they do or they don't?

MR. SAGER: They receive very little treatment at any institution other than Mid-State, which does provide at least a modicum of sex offender treatment, because they have a lot of the sex offenders there.

In answer to your question, I am not aware of any study that has been done to determine the recidivism rate of sex offenders at the other programs who do not receive treatment.

MR. PLANTIER: I don't think those numbers are being tracked.

ASSEMBLYMAN HOLZAPFEL: But it would not be that difficult to find out, would it -- in other words, through the State Police, as far as their rearrest -- as to whether or not they are being rearrested for sex offenses?

MR. PLANTIER: The Department maintains some overall figures. I could not speak for them to tell you how easy or how hard it would be to pull them out.

ASSEMBLYMAN HOLZAPFEL: Okay. Understood. We will try to get that answer.

The only other question I have is: I notice from the report that New Jersey, as far as having a separate institution to handle sex offenders-- There are only two in the country like that, that you know of?

MR. PLANTIER: I am not aware of any other state that has a separate institution to handle just sex offenders.

ASSEMBLYMAN HOLZAPFEL: So we are unique, in that we are 1 of 50-- We are the only one that you know of that has a separate institution?

MR. PLANTIER: That has a separate institution, correct.

ASSEMBLYMAN HOLZAPFEL: Now, the other jurisdictions, do they do it within their own institutions -- the treatment?

MR. PLANTIER: It would vary greatly from state to state. Many states have programs that are run by Human Services, small programs that they cull out. I think the largest group now runs programs in other correctional facilities, and they are run by Corrections.

ASSEMBLYMAN HOLZAPFEL: I think Mr. Sager referenced Vermont. Now, Vermont, is that a correctional facility program?

MR. PLANTIER: It is a correctional program.

ASSEMBLYMAN HOLZAPFEL: And that is within their prison system?

MR. PLANTIER: It is a very small program. It is very selective as to how the men get in, but they provide a nice program there, yes, for a small number of people.

MR. SAGER: May I respond to that?

ASSEMBLYMAN HOLZAPFEL: Oh, yes.

MR. SAGER: Excuse me. I think they are separate, though. I think their population is separate from the main institution. I could be wrong; I am not sure.

The other thing I want to say is, we have attempted to run therapy programs in each of the 21 county jails when we had backlogs and we had to reach out and try to do our therapy in the county jails. I also worked in a county jail for awhile. I worked with sex offenders in the Middlesex County Jail for a couple of years. I would just like to point out that sex offender treatment in a regular jail type of setting, or a regular prison type of setting, is very difficult for one particular reason. Sex offenders are put down in a regular prison. They are sometimes beaten; they are sometimes hurt in other ways, because they are sex offenders in regular institutions.

The upshot to that, when you try to do therapy in a regular institution, is that they are very quiet and very secretive, much the way they are out on the street, and much like their deviant behavior is rooted in. It is very difficult to do therapy in that type of a setting.

ASSEMBLYMAN HOLZAPFEL: But aren't the 40-odd percent that we are talking about -- and I do not want to hold you to a number -- who are sex offenders, first, second, and third degree sex offenders, who are next door in Rahway-- I mean, they are in those prisons and they are not-- I am assuming that they are not being subjected to anything, other than the pecking order that sex offenders-- I used to be a county prosecutor, so I have a little bit of understanding of what you're saying. Sex offenders are on the bottom step of the prison ladder as far as respect within the prison population is concerned.

MR. PLANTIER: They are not clearly identifying themselves. They are not trying to be identified as sex offenders while they are in those jails.

ASSEMBLYMAN HOLZAPFEL: I just want to try to get to one issue: How much are we spending here versus -- if you can tell-- If this was just a prison here-- Your total budget is how many millions?

MR. PLANTIER: Twenty-nine.

ASSEMBLYMAN HOLZAPFEL: Twenty-nine million. Of that $29 million, how much of it is-- If tomorrow this became a 750-bed prison facility for a mixed bag of prisoners, how much of that $29 million would be necessary to maintain this as a prison as opposed to the Avenel Treatment Center?

MR. PLANTIER: Probably all but about $2 million, at the most.

ASSEMBLYMAN HOLZAPFEL: So you're saying that about $2 million would be invested in the treatment end of the facility?

MR. PLANTIER: Yes. I am also talking about the outpatient program and some other things we would throw in, in the same light, yes, approximately.

ASSEMBLYMAN HOLZAPFEL: Okay. Thank you.

Thank you, Senator.

SENATOR BASSANO: You're welcome.

Assemblywoman Turner?

ASSEMBLYWOMAN TURNER: Your inmate population seems to be growing like Topsy. I see where in 1981 you had 200 inmates, and today you have roughly 700. Can you tell me the number of psychiatrists, psychologists, and licensed therapists you had on staff in 1981 when you had 200?

MR. PLANTIER: We have that.

MR. SAGER: I don't know if we have it right available. I believe it would be in the blue book, if we have it at all.

MR. PLANTIER: In 1981-- We had a population by the end of that fiscal year of 209. We had 10 therapists employed.

ASSEMBLYWOMAN TURNER: What about psychiatrists and psychologists?

MR. PLANTIER: Well, that's the psychologists, the number I am giving you.

ASSEMBLYWOMAN TURNER: That's 10?

MR. PLANTIER: Right. The number of psychiatrists at this institution-- We have never been budgeted for more than one full-time position, so it probably would have been one.

ASSEMBLYWOMAN TURNER: What about licensed therapists?

MR. PLANTIER: This particular sheet does not show that, but my recollection from that year is that there probably wasn't anyone who was licensed.

ASSEMBLYWOMAN TURNER: Today, with the 700, how many psychiatrists, how many psychologists, and how many licensed therapists do you have here on staff?

MR. PLANTIER: We have 17--

MR. SAGER: We have 17 psychologists altogether. We have 3 part-time psychiatrists. Of the 17 psychologists, 6 are licensed; 3 are at the Ph.D. level awaiting licensure, awaiting examination, or awaiting experience before they get licensed; and 9 are at the master's degree level.

MR. PLANTIER: Actually, we have the largest ratio of licensed psychologists to staff that we have ever had in this institution right now.

ASSEMBLYWOMAN TURNER: In your therapy, as I understand it, they receive one session per week.

MR. PLANTIER: Typically, all men would be assigned to one therapy group -- primary therapy group -- that would meet once a week. Now, that is just the basic therapy. They could be involved in many of the ancillary programs that Wayne has spoken about. They could also be involved in paraprofessional therapy. They may be given a second-opinion therapist and be involved in that therapist's group also. We do not limit the number of therapies that they can involve themselves in. The basic therapy would be once a week, though, for approximately one and a half to two hours.

ASSEMBLYWOMAN TURNER: What is the average number, then, of therapy sessions for each inmate here per week?

MR. SAGER: I think, off the top of my head-- It looks like we do not have statistics on that.

MR. PLANTIER: I do have something, but go ahead.

MR. SAGER: Off the top of my head, I would say probably about four hours a week or so, on average. But you have to consider the fact that some of the people we have here aren't really seriously involved in treatment. They might go to the primary therapy group and that would be it. Whereas the people we have who are really interested in therapy could go to therapy every day. We do have the possibility for them to go into ancillary groups, as Bill said, and other types of groups, so they could be involved five days a week in the treatment process.

Now, when you do get into the treatment process and you see that somebody is involved in it, it is pretty strong medicine. For someone to be involved in it for an hour, for two hours a day, every day, that is really quite a bit of therapy. I don't know of too many places that would provide any more therapy than that in the course of a week.

ASSEMBLYWOMAN TURNER: Well, isn't this a diagnostic and treatment center? I guess, perhaps, I am expecting to see more than I do. I see a lot of downtime here today. I don't know, what is the typical schedule for an inmate here at this facility?

MR. PLANTIER: A typical inmate here-- All inmates in the institution, if they are medically capable of it, are assigned to work a job. So they all have a job to do within the facility. That job can be anywhere from a half a day to a full day. Kitchen jobs are typically a half a day. They would also be assigned to an educational program if they were interested. With the waiting list they could get on an educational program, either an adult basic education program or

a GED program. That would be a half a day. So they would work, typically, for half a day, be in a GED program for half a day, and then as many therapies that they happen to be involved in would make up the rest of their day. They are excused from work and from education to attend therapy. That would be a typical day for most offenders.

ASSEMBLYWOMAN TURNER: What time does their day start, and what time does it end?

MR. PLANTIER: Well, it varies with the job. Some men-- Today, as you were walking around, you saw people sleeping. Some men would be on their Saturday or Sunday in terms of their regular day off today, and they would work on the weekends. Some people work at night. People work around the third shift. So you have people at all stages either recreating, going to work, going to school, sleeping, or what have you, at all different times, because it is all broken up, a.m., p.m., third shift, and around the other various programs they are involved in, including their days off-- Almost all jobs in the facility are five-day jobs, so everyone has two days for which they are not paid.

MR. SAGER: There are two other things to say after that: Number one, when we were walking around, we were walking around during count time. I believe it is three times a day that we have count time. At that time, the men have to be in their living unit. They just have to be there so that the count can take place and we can make sure that everyone who is supposed to be here, is here.

The other thing I wanted to say as far as therapy is, we tried to extend therapy in spite of the numbers problems we have. There is writing therapy. Just about every therapist we have here will give a journal or a therapy notebook out. The inmate will write, when he has a chance to, and then give it back to the therapist, and the therapist will make responses on it. It will go back and forth that way. It is not the same as

face to face, and in a lot of ways it is not as good as face-to-face therapy, but it is a way we have to extend therapy. In one way it is better, because it gives the person a chance to think. When you write something down, you have to think a little bit more than if you just say something. So it does have its therapeutic positive point to it, too.

ASSEMBLYWOMAN TURNER: Okay. Thank you.

SENATOR BASSANO: Assemblywoman Crecco?

ASSEMBLYWOMAN CRECCO: Thank you.

I understand that you do not have the facilities here to collect hard data on progress in the treatment of prisoners. You really can't tell what the progress is or what the rate of recidivism is exactly, since your last count was somewhere in 1985. Would it not be more advantageous to you as far as the reason for having this Treatment Center here and knowing what the progress is, to have that data here, and have the staff here to do that?

MR. SAGER: There is no doubt about it. If we had an ongoing recidivism study so we knew the statistics all the time, we would be in much better shape. We would be in better shape today reporting to you about the efficacy of our Program. We also would be in better shape in terms of being able to mold our Program and shape our Program, because we would be in a better shape to know what works and what doesn't work. At this point, I would agree wholeheartedly, and I think Mr. Plantier would, too. As I said, it is a matter of numbers. We had to rob Peter to pay Paul. We had to take our research person and put that person into a clinical job in order to get the clinical job done, at this point.

ASSEMBLYWOMAN CRECCO: You get your information mostly from the Department of Corrections, actually. So would you suggest that you should have those facilities here?

MR. PLANTIER: I can only reiterate what Wayne said. We certainly would like to have the ability to have a database,

but, you know, you have to realize first that this is a correctional institution. Our mandate is to provide treatment for the offenders given to us. We have just been given overwhelming numbers over the last decade. The first thing we had to do was provide treatment the best we could for the people we had. As Mr. Sager has said, the issue of culling out people to provide research is something we would love to do, but when we have a numbers crunch, we obviously have to take care of what our mandate is, and that mandate is the treatment.

ASSEMBLYWOMAN CRECCO: I appreciate that, but what I am saying is, since you are mandated to treat, you can't determine the progress if you don't have the proper database there.

MR. PLANTIER: I agree. I have found it to be a very valid criticism, and certainly one that we would like to have addressed.

ASSEMBLYWOMAN CRECCO: Thank you.

SENATOR BASSANO: Senator McGreevey?

SENATOR McGREEVEY: From what I understand, the national statistics show the recidivism rate substantially higher -- 33 percent to 71 percent. One thing that I am concerned with -- this is not a fact at this institution -- is the selection criteria for entering into treatment. It is perhaps one of the most problematic areas for treatment programs, particularly such as this institution. Can you tell us -- enlighten us as to what the selection criteria are for entry into this particular Program?

MR. PLANTIER: Well, first, you would have to be convicted of one of the enumerated sex offenses, typically the first, second, or third degree offense or attempt to commit those. At that point, you would then be scheduled by the court and by the probation department for an evaluation here at the Adult Diagnostic and Treatment Center. The evaluation would be performed by a psychologist, and the determination as to

hether you were a repetitive/compulsive sexual offender-- That, in simplified terms, is repetitive, having either committed or admitted to more than one act, and compulsion being the mental mechanism, or urge to act out in that way sexually. In other words, unable to control one's sexual behavior.

The psychologist typically provides a battery of tests and conducts a clinical interview. The results of the test are scored, and along with that clinical interview, the psychologist then writes up a report for transmittal back to the court, for sentencing purposes. As part of that conclusion, he would make a finding as to whether that offender's actions had been patterned by a series of repetitive/compulsive sexual behaviors or not. Those found to be repetitive/compulsive by the court would then be sentenced, or eligible for sentencing to the ADTC; those not, would not be.

SENATOR McGREEVEY: I assume, to follow Assemblyman Mikulak's question, that there are a variety of pharmacological interventions that are typically used, medroxyprogesterone acetate, cypterone acetate-- Are any of those presently being utilized to treat sex offenders in this unit?

MR. SAGER: We don't use them in this institution. I think the best way to answer that is-- There are two major reasons why we do not use them in this institution: One is, we do not necessarily want to mask what the sexual problem is while we have the guy behind bars and while we are trying to treat that problem. We want him to report it to us. We want to see what that problem behavior is, so we can treat it in our group therapy. So while the person is here, at least during the first couple of years he is here, we probably would not be that interested in using that type of modality. If he was getting near the end of his sentence, if we wanted to see how that type of thing worked, and if he reported that he had a

problem in this area, that he was having a problem controlling this type of thing, then we would probably start to use them.

These things are changing all the time. At this point, we are still learning a lot about these things. So we have not begun to use them too much in this institution. I think we are probably going to use these things more and more as time goes on, not so much yet.

The other main reason why we don't use them at this point is because we have not been able to get a plythesmagraph, which is an apparatus that is used to measure deviant arousal patterns. We do not have an equipment budget, and we have not been able to purchase one yet. Until we have something like that, or a polygraph, or something else that helps us to determine deviant arousal patterns, other than just asking the man what his deviant arousal pattern is, this modality will be difficult. That is another reason why we are slow to use that.

Now, once somebody gets out and back on the street, then we would refer a man who did have a problem in this area to a psychiatrist who is able to deal with this type of medication, so that we could--

SENATOR McGREEVEY: I guess one of the questions, whether it is MPA or CPA, is, is this not an effective methodology for reducing sexual activity or an inclination to control full levels? I do not understand why this would not be described as a fundamental requirement.

MR. SAGER: Well, the literature that I have read on this-- I am certainly not an expert; I think psychiatrists mostly are experts in this field. What I know about it is that the recidivism rate for people who are put on this type of medication is very low, so it is effective as far as that goes. The problem areas that go along with the good recidivism rate are certain side effects and the fact that a lot of people will not stay on this type of medication. What they do is

recommend that if this type of medication is used, that it be used in conjunction with the type of therapy that we do. It would be a conjunctive type of thing if we were to use it.

I think it is probably an area that we certainly need to look into. It is an area where we probably could do better, to be quite frank with you.

SENATOR McGREEVEY: I just have somewhat of a difficulty in distinguishing between nonbehavioral approaches and cognitive behavioral ones, since from what I have heard, there seems to be an integration between the two approaches.

MR. SAGER: Yes, sir.

SENATOR McGREEVEY: Have there been any recidivism studies that have differentiated behavioral approaches opposed to cognitive behavioral therapy?

MR. SAGER: I am familiar with one recent behavioral study done by Quinsey in Ontario. That is the one study I am familiar with that has been fairly recent. That study reported good recidivism rates, similar to the recidivism rates for the cognitive behavioral type of approach. We use both here. We do not make that big of a distinction between those two types of modalities.

SENATOR McGREEVEY: The other question is: As you monitor sex offenders over a longer period of time, doesn't recidivism increase?

MR. SAGER: Yes. That seems to be true in almost every study that I have read. It is one of the things that I think points to the idea of lifetime supervision--

SENATOR McGREEVEY: Yes.

MR. SAGER: --and continued therapy for a long time after these guys get out into the community. I think a couple of our latest failures, the more serious failures that we have had in this Program, have been men who have been out of this institution for quite some time. So that certainly seems to be the case.

SENATOR McGREEVEY: But it seems, from the literature -- and you reiterated this -- unequivocally clear that in addition to cognitive behavioral programs, there is a clear necessity for pharmacological treatment, as well as lifetime supervision, especially in light of recidivism trends over an extended period of time. Is that correct?

MR. SAGER: I believe there probably would be some problem with the pharmacological type of treatment over time, both because of side effect issues and the reticence that men might have to take this medication over a long period of time. I don't think we are at the stage now where men could have a normal sex life while they are under this medication. That would make it difficult for them to agree to take it for years and years and years.

SENATOR McGREEVEY: I am just looking at it from the point of protecting-- I am interested in protecting society. From the point of protecting society, what is the most responsible, appropriate--

MR. SAGER: I think the most conservative approach would be to give the medication. From a practical standpoint, from someone who works with these people in the community, I think actually getting it done would be more difficult than that. It would be a very conservative approach and it probably would work well, if we could get it done.

SENATOR McGREEVEY: Thank you.

ASSEMBLYMAN MIKULAK: Just an interjection: It would seem to work with parole, with a longtime parole, this medication.

MR. SAGER: In other words, give the guy the option to take the medication, or else he would be returned to an institution.

ASSEMBLYMAN MIKULAK: Well, yes. He would be on parole, and the condition of the parole, in some cases-- I mean, the responsibility in this institution is not to get the

offender back to his normal sex life, but, as Senator McGreevey said, to protect the community.

MR. SAGER: Certainly. The only thing I wanted to speak on was the practical idea of getting someone to go along with what you want them to do. That is another thing.

SENATOR BASSANO: The Program you are using, has that ever been evaluated by an outside person?

MR. SAGER: Our Program now? Yes. The Assistant Superintendent and myself were at the National Institute of Corrections this past February, where we met a consultant from the National Institute of Corrections, a woman, a licensed psychologist who is an expert in the field of sex offenders. We had her come to the institution for a week in May to look at our Program and to judge our Program compared to other programs in the country. She has a report, which we will make available to the Task Force.

SENATOR BASSANO: We would like to see that, if we could.

Senator Inverso, do you have some questions?

SENATOR INVERSO: I think you just asked my last question, but I have a couple of other comments to make.

From what you have said in response to the questions raised, it is clear, to me at least, that some of the legislative initiatives we put into place by the Governor's signature yesterday are going in the right direction. In that regard, I do have one or two maybe general questions for you.

Have you performed a self-assessment of your success here at the facility?

MR. PLANTIER: Self-assessment in terms of recidivism?

SENATOR INVERSO: Well, obviously you do not have the recidivism numbers, and that is critical, it seems to me, if we are to make a comparison of whether the dollars we are putting into place here are better spent than putting those dollars into the general penal system and having programs as ancillary

to that. So we need to get those numbers, and I am sure you will see that we get them. If we have to help you with the resources, I'm sure we will be there for you.

The question I am raising is this: We have programs. You indicated that modality is based somewhat on the Vermont modality. I guess sex offenders are sex offenders, whether they are in New Jersey or Vermont, although we may have a different socioeconomic composite. I don't know what Vermont may have, let's say, in some categories. In having the evaluation of the Program that you indicated you went through in response to Senator Bassano's question, I am wondering whether internally here you have looked inside and said, "Okay, how well are we completing our mission? What do I need to complete this mission? As with school children, you cannot be responsible for what happens once an inmate leaves this facility.

Our responsibility is to see that the community is safer from the degree of risk it is exposed to; that the risk is much less when they leave here today than when they came in here. So what do we, as State government, need to do to respond to that, that goes beyond what we responded to in yesterday's legislative package?

So, one, have you done a self-assessment of how well you are fulfilling your mission here?

MR. SAGER: It is hard for me to answer that without thinking about recidivism types of things. Now, we do, internally, look at our programs all the time. We have meetings once a week with the treatment staff in which we deal with clinical issues and try to determine which programs seem to be working well, which do not seem to be working well. At this point, we have a treatment revision initiative, where we have broken up into small committees and have begun to outline each of our programs, bring them before the committee, make sure this is exactly what we want to do, and have it in such a

module so that each psychologist will be able to do exactly the same thing, and we all know what page each other is on. We are doing that.

Another thing we have done fairly recently is look at the recidivists who have come back to this institution. In other words, look at our failures. We interview these men in detail, in maybe one-hour, two-hour, three-hour interviews, to try to determine from our interviews with these men what went on in their lives, what happened, what could have happened in their therapy while they were here to keep the recidivist from recidivating. Was there anything about the Program, was there anything about their life that we needed to know in our therapy Program to change it?

Are these the types of things you are interested in?

SENATOR INVERSO: Yes, that is what I am responding to. I mean, it has to be a dynamic process, obviously, because--

MR. SAGER: It is always changing.

SENATOR INVERSO: There is very little we can compare you to with regard to the approach institutionally, since New Jersey seems to be unique with regard to how we have approached this problem. For us to determine how well you are doing your job, I need to know whether you have, through self-assessment, made a determination that what we are doing is achieving the end results. If it is not, what do we need to do to implement new approaches, new modalities.

From what I have heard from you, you are satisfied that at this point in time you are achieving the mission that we in the State Legislature said, for $28 million, we want you to achieve.

MR. PLANTIER: I think, again, that that is hard to answer. We certainly look at what we do, and we certainly, as Wayne has been talking about, are critical in terms of what we do and how we look at it. As he mentioned, we are right now,

and have been for apparently the past six months, in the process of looking at the entire Treatment Program, what we're doing and how we're doing it; also, what emphasis we are placing on different components of that Program.

I think we have learned some things from that, but I think until you start to do some research and some pre-test/post-test, I think what we are talking about, again, are impressions. Until we have some resources to do a little bit more of that-- I think it is something that very, very much needs to be done, because what you are getting and what you are hearing are going to be impressions, because we are not budgeted to do the research. We have not been able to do the pre-test/post-test to actually give us some hard data to come back with. It is something we need to do, and it is something we would like to do.

SENATOR INVERSO: What is it you would like to have in place now to help you to achieve this mission in a more positive fashion? In other words, it seems to me that you are satisfied. That is not a pejorative term, but you are satisfied that the therapies and the treatments in place here are having a beneficial effect on the inmates here, and ultimately on the communities, because these inmates are going to be released into the communities, and that is our prime concern. So you are satisfied.

But what is it beyond that that you need to do to help even more to provide a sense of security that upon release, and upon the implementation of the extensive continuing supervision, upon the implementation, perhaps, of more outside therapy and counseling, which we in the Legislature have to address-- What is it you need to do to make your job even more complete?

MR. PLANTIER: I think we have put together a list of where we would like to see expansions in the Program in terms

of staff, in terms of dollars, where I think they would be well spent.

SENATOR INVERSO: Have you provided us with that list?

MR. PLANTIER: I have it here for you. I would be glad to give all of you a copy of it. That is pretty much what we have come up with right now, an attempt not to just gild the lilly, but to provide some things in the institution that we feel we are clearly deficient in. One of those areas, clearly, is research. We need to do more there. We need to be able to tell better whether what we are saying is what we are doing. In other words, we hypothesize that this Program produces this effect or that effect. We have nothing to prove that hypothesis. Until we can get in and start doing some serious research, you know, again, we are just giving you theories and impressions without giving you anything really solid to work with.

So in terms of a database and a research initiative, I think it is very, very important to give you what you need to better evaluate us.

SENATOR INVERSO: Right. It becomes a very, very difficult process. As you say, it is pure anecdotical sometimes. We have to approach it in terms of, how do you measure the results? It looks as if right now it is hard for us to measure results, although some of the information I have been browsing through that you have supplied to us shows that our rate of recidivism is down, compared to other states that have other programs and compared to the general prison population as a whole. That is a positive, it seems to me.

Beyond Avenel, what is it we could do? Obviously, you are aware of the legislative package that was passed yesterday. Is there anything missing in that composite in terms of addressing the problems of sex crimes, the offenders, and the need for going forward?

MR. PLANTIER: In terms of addressing juvenile offenders, I think a lot more needs to be done. You know, we have had very little for them for many years. This is typically a problem that begins in adolescence. I think if more can be done to deal with juvenile sex offenses-- When you take a look at the whole issue of juvenile crime, I think more needs to be done in those areas. I think if you can better address and treat juvenile offenders, you may someday stop seeing the high numbers that you have here. I mean, it is not a guarantee, but I think it is an impression that everyone has.

You know, we have done a lot at Avenel. I think there are some things where we could do more and we could do better, but I think that that is certainly an area where a lot could be done.

SENATOR INVERSO: Mr. Sager, can a sex offender ever be cured, in your opinion?

MR. SAGER: In my opinion, I think there is probably a very small percentage of people who, after you supply them with good treatment, probably we do not have to worry about anymore. I think that probably can be construed as a cure. By and large, however, I think sex offenders can be managed. Let me edit that a little bit. A large percentage of sex offenders, if they are motivated for treatment, can receive treatment and can then be managed safely for the remainder of their lives. I think there are some people that we won't be able to reach, tragically. No matter what we give to some people, they are going to go out and commit crimes. They are going to commit serious crimes again.

Another thing that the literature shows that I wanted to make sure to say is, rapists, particularly very violent rapists, particularly people who have a history of violent and sexual behavior, are usually the people who are the most difficult to treat and who have the highest recidivism rates. I want to just suggest that that particular subgroup of sex

offenders is the most dangerous, probably the type of offenders who need at least long sentences on the back end, so that we can keep them for a long period of time, if it is necessary to.

That is something that I think probably could be addressed, and probably should be addressed.

SENATOR INVERSO: The 90 percent rate of participation in the therapy programs here-- Is that a recent phenomenon, or is that something that has occurred for several years?

MR. PLANTIER: It has always been there. There has always been a small percentage of men who, for whatever series of reasons, will not participate. They break down pretty much into a couple of categories: There are some who are doing it on the advice of their attorney. Their case may be in appeal, and you see that a lot. You know, "My lawyer told me I can't participate. I can't talk about it." Some of them come back into therapy after their legal appeals have usually gone nowhere.

The other group, which is a very, very small group, thank God, is people who really don't believe they have done anything wrong. The North American Man/Boy Love Association, NAMBL as it is known-- We have a few people in here who would belong to that organization. They clearly are impossible to treat, because they just simply do not feel there is anything wrong with their activities and their behaviors.

So, they would tend to be the groups.

SENATOR INVERSO: All right, but that rate has been consistent over a fairly long period of time.

MR. PLANTIER: Yes.

SENATOR INVERSO: As I mentioned to Mr. Sager earlier, from what I have read, I guess in the newspapers, the rate of participation was a lot lower than 90 percent. So I am glad that that has been made clear on the record.

MR. PLANTIER: I think when we talk about that, though, we talk about the level of participation. I am talking

about people who are not participating. There are others who are paying lip service to treatment. I can't give you an honest percentage of how many that is, but there are going to be people who are doing the basics to get by, so that they do not get labeled in that solid label of a "therapy refusal."

So there are people in the Program that run from highly, highly motivated-- Maybe that is half. I am not even sure, Wayne, if that is a good number to people whose motivation would then go down on a sliding scale after that to none at all. So you run the gamut in here.

SENATOR INVERSO: What is your most pressing need here at Avenel that you want to leave with us today? Is it more therapists, more counseling? What is it? Tell me what it is.

MR. PLANTIER: I would like to see a couple of areas. I would like to see additional therapists. I would like to have a position where we are not so concerned about our psychologists burning out with the caseloads they have and moving on. I would like to see more done in the way of after care. And, as mentioned earlier, I would very much like to see some research, some database established whereby we can look a little better or a little more critically at what we do, instead of just giving you impressions.

MR. SAGER: May I mention two other wishes I have? One is an equipment budget, because, as I mentioned before, we do not have a plythesmagraph. We don't have a way to measure deviant arousal patterns. That would not cost a lot of money, but we do not have an equipment budget, so at this point we don't have it.

The other thing is a training budget, which is another thing the Department of Corrections--

SENATOR INVERSO: A training what?

MR. SAGER: A training budget. The Department of Corrections does not have it at the present time. What we do is, we will send our therapists to national conventions and

things like that. If they are willing to pay their own way, we will give them the time off. But we are not able to encourage them any more than that. If we had even a small training budget to send someone once every other year at State expense to training specifically to sex offenders, which is a very specific type of training that is handled on the national level, that would help us out a lot. I think that would upgrade our Program significantly. We would get much, much more than the amount of money we put in for that.

SENATOR BASSANO: Who does that training program? Who puts that on?

MR. SAGER: Well, training programs are done by other programs in other states. There is also an Association for the Treatment of Sexual Abusers. There are probably about 1000 people throughout the country who belong to that right now, experts in the field throughout the country who treat sex offenders. We have been involved in that, because our people have gone on their own over the past couple of years to conventions and things like that. If we could encourage them more, it would be helpful.

ASSEMBLYMAN MIKULAK: This is a question for the Department of Corrections: With the $574-million-a-year budget, I am just wondering why they can't give this facility enough money to fund a recidivism study. There isn't any lack of money in Corrections overall. Maybe this facility is crying "poverty," and maybe it is impoverished. The Legislature hasn't impoverished this facility.

MR. PLANTIER: Frankly, the only thing I can say is, the institution did not suffer any more cutbacks or any less cutbacks over the last three years than any other correctional facility. So we were certainly never singled out by the Department for any specific cuts. I think everybody suffered equally. We suffered from loss of staff and loss of funds, as

everyone else did. So I would hardly want to reflect that there was something special that happened here.

ASSEMBLYMAN MIKULAK: This is all relative, because when you are talking about cutbacks in Corrections, you are talking about increases not keeping in line with what they feel they need with the prisoner population. But over the last 10 years, this facility has averaged a 15 percent increase. That is from the statistics I have. Maybe we started low, I don't know.

MR. PLANTIER: We probably did start low, but we also grew dramatically. If I could best sum up the decade of the '80s, this institution was undergoing unprecedented growth. We spent an inordinate amount of time trying to keep up with that, just finding beds for these people. Our treatment budget grew with it, but, unfortunately, with the sheer numbers of people we had to deal with, we were basically being swamped.

ASSEMBLYMAN MIKULAK: Thank you.

SENATOR INVERSO: I want to thank Mr. Sager. He was kind of our co-tour guide. I was very impressed with both individuals, in terms of their openness, frankness, and willingness to respond to any and all questions. I am satisfied that we have some good people.

What we need to do is help you to do your job better, and we need to be able to evaluate how well the mission of Avenel is being achieved. It does concern me that we do not have some of the statistical information in place, but we will work to that end. But I think we have a good corp of individuals here, at least those I met today, fulfilling, as well as they can, that mission.

MR. SAGER: Thank you.

SENATOR BASSANO: That, I think, is the opportunity before you now, to make the system better. That is why we are here.

MR. PLANTIER: We very much appreciate that.

SENATOR BASSANO: Senator Malone?

ASSEMBLYMAN MALONE: Just a couple of questions: In coming here today, I thought one of my main missions was to try to look very closely at the programs you are offering to rehabilitate individuals. Would you say that today's visit represented the activities that go on during an average day?

MR. PLANTIER: Yes. Obviously, this many individuals coming through for a tour of the facility is going to have major impacts on us. Mr. Hilton is here. He is the Chief of Staff, the number two man, in the Department. He made it very clear to me that we were going to run, to the extent possible, a normal day here so you could see what went on. I think as we went around -- this would be with one of the tours, I can't say what everybody saw -- you saw a lot of therapy being run. If we had not been breaking down for lunch, you probably would have seen a lot more programs.

ASSEMBLYMAN MALONE: Okay. I guess that was the reason for my question. I guess that is maybe what I didn't see today being here. I didn't see a lot of therapy. I saw a lot of sleeping and eating habits, but I didn't see a lot of therapy being done today. I guess that is my concern, that if the mission we are going on is to try to evaluate your Program, and we come here and 90 percent to 95 percent of the tour was sleeping and eating habits-- I am concerned about that.

MR. PLANTIER: Well, as I explained before, the men work on different schedules. They have different time frames to do their jobs. They have different days off from their jobs. There are going to be men sleeping, no matter what time you walk around this facility, be it day or night. That is just what happens when you have so many jobs in a facility this small, and you are trying to get everybody to work. You do not have major work programs. The only major work program the institution has would be that DEPT Cort Center we showed you.

So certainly, you know, while it is not on our major list of things to do, we would certainly like more work programs, more meaningful work programs. Certainly, if DEPT Cort, the State use industry program, would be willing to give us more, we would certainly take them. But we have no other shops to show you. We are not kicking out lockers or making beds. So a lot of the work we have to do in this facility, as it would be in a lot of the facilities, is make-work. So, yes, the men-- There are a lot of men whose jobs here are as porters. Our largest employer is in food service. We give everybody jobs, but we can't give everybody jobs that are going to last six or seven hours a day. They just do not exist.

ASSEMBLYMAN MALONE: With the exception of the $2 million that you say you are using on the programs, how would you say this facility differs from any other facility we have in the State?

MR. PLANTIER: The only thing that would probably drive the cost up here is-- Still, you are only talking of about a 740-man facility, whereas if you had a 2000-bed facility, or larger, I think your costs would be kept down just because everything else is larger. It is borne out by a larger--

ASSEMBLYMAN MALONE: Yes, but you mentioned that you are basically spending $2 million on the Program, and the rest is basically institutional costs. On a per inmate basis, how does this rate as far as other institutions are concerned, do you know?

MR. PLANTIER: I do not have an exact figure for you. I can get it.

ASSEMBLYMAN MALONE: Give me a ballpark figure.

MR. PLANTIER: I am thinking we are about 27.

MR. SAGER: Yes, 27, 28.

ASSEMBLYMAN MALONE: Twenty-seven thousand?

MR. PLANTIER: Yes.

ASSEMBLYMAN MALONE: When you bring your inmates in, do you do a workup on those inmates?

MR. PLANTIER: Yes, in every case.

ASSEMBLYMAN MALONE: I didn't hear you.

MR. PLANTIER: Aside from the diagnostic workup that I have already spoken of.

ASSEMBLYMAN MALONE: When someone comes in, do you know what you have on your hands? I mean, do you do some kind of a psychological profile of that individual so you know how to treat that individual?

MR. SAGER: The best thing we have, and a very good tool we have, is the outpatient evaluation that is done. I have seen a lot of psychological evaluations in my time, and they are among the best. We have a very good psychologist doing those evaluations. They are what we use more than anything else. We also use presentencing reports, police reports, and things like that. If there is any other psychological data we feel we need at the beginning of treatment, the psychologist who has been given the case will take care of that, will do that. Usually, we can get started in therapy with the outpatient evaluation. That is usually a very good--

ASSEMBLYMAN MALONE: So you do have an individual program set up for each inmate?

MR. SAGER: Yes, we do. We have had that all along. We are working on changing it a little bit, making it a little bit more specific. But from the very beginning, we do six-month reviews on each inmate that are reviewed by the Special Classification Review Board each six months, in which we say what the problems are, what the therapeutic goals are, and what still needs to be accomplished before the man is put up for parole.

ASSEMBLYMAN MALONE: I am going to assume that you have some documentation as to what programs you offer. I don't

mean, in a real sense, the curriculum, but if I wanted to leave today and get a package of the programs you offer, could we have a copy of the programs, and so forth?

MR. SAGER: We have that in the back. I also wanted to mention, in response to your other question, we run-- I think we run about 140 groups a week here, every week, about 35 different types of groups every week. Sometimes you don't see exactly what is going on, but we certainly do run a lot of groups. We make sure that those groups run week in and week out, because that is what we feel we do here.

ASSEMBLYMAN MALONE: Just one additional question: Do you ever get the feeling that the-- How can I say this? Do you ever get the feeling that maybe your philosophy on treating these types of offenders may be wrong?

MR. SAGER: The only way I can answer that question is-- What we have to do is refer back to the research. We have to refer back to the expertise that is in the field. We have to see what other people say. It is a fairly healthy field in terms of people arguing with each other and people having different ways of looking at things. So I think as long as we go to our conventions and we keep up with our research, we are able to do that. We are able to evaluate ourselves and our approach to this thing by listening to what other people have to say.

ASSEMBLYMAN MALONE: I would say that the general perception of the public is that the criminal system has failed. I am just wondering if you have any kinds of feelings about maybe the philosophy, not just in New Jersey, but all over the country, may be one of failure, as opposed to looking at other alternative methods, maybe from other countries or something, to be a little more successful in the kinds of individuals we are putting out after treatment.

MR. SAGER: Well, we are in a field where tragedies happen from time to time. We will work with five people, and

four of the people we might make progress on. The fifth person might go out and hurt someone badly, or kill someone. If anything is going to give us room to fall as we think about what we do, something like that does, and that has. It has with me, and it has with the treatment staff over the past couple of months.

The only thing I can say in response to your question is, yes, those types of things bother us a lot. That gives us the motivation to look into other ways of doing things, to be self-critical, and to just do the best we can as time goes by.

ASSEMBLYMAN MALONE: To follow up on Senator Inverso's last question about evaluation, it is nice to get someone who works in another institution, maybe in this State. I mean, they have a certain perspective on things. But did you ever think about bringing in other professionals, because this, I would assume, is a mental health kind of a situation that you can't-- Why wouldn't you bring in a team of other mental health experts to evaluate your programs to see if, in fact, they are appropriate and are as effective as possible?

MR. PLANTIER: We just did that. A report we have for you was done by Dr. Steele, who is an independent consultant for the National Institute of Corrections.

ASSEMBLYMAN MALONE: Okay. Tell me somebody outside of corrections, someone who has no connection with correctional institutions, somebody, I don't know-- Pick an institution that is private and does not have any connection with correctional institutions, that comes in and does a real nuts and bolts evaluation of your program.

MR. PLANTIER: I think that would be fine is someone was going to pick up the freight to do that. Those people do not work free, you know.

ASSEMBLYMAN MALONE: I understand that.

MR. PLANTIER: That would certainly be fine.

ASSEMBLYMAN MALONE: Thank you, gentlemen.

SENATOR BASSANO: Assemblyman Holzapfel?

ASSEMBLYMAN HOLZAPFEL: Mr. Sager, I know we were using that 90 percent number. I am referring to an Asbury Park Press story back in August of '94. It said-- It has you quoted as saying-- "Only one-third of the 714 inmates are keenly motivated, said Sager, the head of the Psychology Department. Another third are moderately enthused, and the remaining men have little or no interest in being helped." We were talking about 10 percent--

MR. SAGER: The 10 percent are the people who do not go to group. They sign a paper and say, "I refused treatment." The third that I was talking about was not only those people, but also people who go and sit there. They do not respond; they don't do well in therapy, or respond to therapy.

ASSEMBLYMAN HOLZAPFEL: Is it 10 percent in the third, meaning 40 percent, or---

MR. SAGER: No, I was breaking the entire population down into thirds, because that is the way I tended to see it over my experience here.

ASSEMBLYMAN HOLZAPFEL: As I understand it -- and I could be wrong on this -- doesn't the Commissioner have the ability to take-- I know he has the ability to put them in here from other institutions, right?

MR. SAGER: Yes.

ASSEMBLYMAN HOLZAPFEL: He has the ability to take them out of here, also, does he not?

MR. PLANTIER: Yes, he does.

ASSEMBLYMAN HOLZAPFEL: Okay. A simple question from my perspective: Why, if a third of these people-- Let's take the 10 percent, the 10 percent who absolutely refuse to do anything. Why aren't they taken out of here and put next door in the State prison?

MR. PLANTIER: As I mentioned earlier, there is concern about them being paroled and getting out of jail sooner. There is also the issue of thwarting the judge's intent. When a judge finds a person to be a repetitive/compulsive and sentences him to this facility, we feel an obligation to at least try to uphold the judge's intent in sentencing and to provide treatment.

The other thing that often happens--

ASSEMBLYMAN HOLZAPFEL: May I just ask you one thing about that? Doesn't that judge base his opinion on compulsive behavior based on your recommendation?

MR. PLANTIER: Yes.

ASSEMBLYMAN HOLZAPFEL: Okay. So, I mean, you are really telling him, "We find that this guy is repetitive/compulsive" -- or whatever -- and he then says, "Okay, I take your recommendation. That is why I am sending him to Avenel."

MR. PLANTIER: Yes, but I certainly think it would be improper of us, at least initially, to take a man and administratively transfer him out if he is not doing therapy. As I spoke of earlier--

ASSEMBLYMAN HOLZAPFEL: What period of time would you think?

MR. PLANTIER: Well, our internal procedures call for at least a year. Our administrative procedures call for at least a year. I think, in many cases, that may be too short. As I mentioned, men are not doing therapy for a number of reasons, one being their legal appeals. When their legal appeals are resolved, they may very well go into therapy, and that does happen.

ASSEMBLYMAN HOLZAPFEL: Why couldn't they be kept in a regular institution until their appeals were up?

MR. PLANTIER: Again, you are playing with not that many people, and you're bouncing balls with them back and forth. You know, I think it is easier--

ASSEMBLYMAN HOLZAPFEL: Isn't that of their own making? I mean, you say they are bouncing balls. They are the ones who are saying, "I am not going to take part in the Program." We are not saying, "We are not going to let you in the Program."

MR. PLANTIER: A lot of them are not saying it that clearly. A lot of them have trouble starting in therapy. A lot of them have trouble beginning -- getting started. You know, a lot of them are afraid to open up. So I think to take and make a hard, fast rule on these guys when there are so many different things at work here in terms of their participation, would not really necessarily solve the problem. A certain amount of them are going to remain that way, and remain steadfast. Now, maybe they could be transferred.

ASSEMBLYMAN HOLZAPFEL: Of the 10 percent, do you have a sense-- Are there some of them who have been here more than five years who are still refusing to take part and their appeals are up? Or, are there people out there -- basically, this is what I am saying -- sitting around playing with their computers, watching TV, waiting their max out?

I have to, maybe, throw in something. I know what you are talking about -- when sentencing was for an indeterminate term. But I think now, with the skips and what have you-- I don't know that someone is going to get out that much sooner. We are working on the parole problem. I don't know that someone is necessarily going to get out sooner by going next door.

How many of that 10 percent do you think you would say in your mind, heart, "Hey, you know what? This guy, no matter what, is not going to take part. I may just as well have my psychologist have a 10 percent cut in his caseload, than to waste time, effort, and money on people who are just not going to cooperate." Could you give me any idea about that?

MR. PLANTIER: I think it is hard to give you a hard, fast idea, because it is a group of people that is, you know, in flux. They are moving from one area to another as we speak. What may be hard and fast one week, may not be the next week. That is hard to answer accurately.

The only thing I would say is, you know, I think we need to give them time to come around. Whatever amount of time that may be, I am not so sure I know. Just simply putting them in, let's say, Rahway or East Jersey, they are overcrowded, too. It is not like you are solving a problem by moving them out. There are not that many. They are going to have to go somewhere. It all backs up on the Department sooner or later.

ASSEMBLYMAN HOLZAPFEL: No, I understand that, but you would be saving money and you would be reducing the workload in this facility. That is another problem. You know, you would not be putting them out on the street. But if you are taking that 10 percent, or say, basically-- They are thumbing their noses at citizens. "We are not going to participate."

MR. PLANTIER: Frankly, another reason why I am not real happy with that kind of an idea is, I can see down the line five, ten years from now, where one of those people we did transfer out, saying, "Forget it," maxing out or what have you, committing another serious offense, and now we are going to have, "Well, look what happened. They threw him the hell out of treatment."

ASSEMBLYMAN HOLZAPFEL: But a large number of them already don't ever get in here. They go to a prison to begin with for a sex offense.

MR. PLANTIER: I would say it would be very few who are labeled repetitive/compulsive who don't come here. I think most of them, the vast majority, are here.

ASSEMBLYMAN MIKULAK: Mr. Plantier, that is what I said in my statement, that this facility has gotten away from its mission. That is one of the areas where it has gotten away

from its mission. The mission is to treat sex offenders. If they refuse treatment, they do not belong in treatment.

MR. PLANTIER: I think there are some general types of agreements on that. It is how specific, and when you give up on a person. I mean, there have been people who were in this program for several years who have started doing therapy. So if I had transferred them out a year ago, or after a year, obviously they wouldn't. I guess anybody could debate this to death.

ASSEMBLYMAN MIKULAK: Maybe if the rules were enforced and the Commissioner transferred people out, they would be in therapy a lot sooner.

MR. PLANTIER: Well, the rules are not hard and fast. The rules allow for a lot of leeway.

MR. SAGER: Things might change now with the new laws, too, because with the new commitment laws, the treatment refusals here are a lot more uncomfortable in their situation as treatment refusal. So it will be interesting to see how they react to that, at this point.

A S S T. C O M M I S S I O N E R G A R Y J. H I L T O N: (speaking from audience) If I may, I don't know if this is appropriate-- The perception is that if they get transferred out of here, they are going to get out of jail soon. If that can be changed so that if you bust out of here for not treating you are looking at long time, then your comments are right on the money.

ASSEMBLYMAN MIKULAK: I talked about that in the beginning.

SENATOR BASSANO: That is what we are looking at.

ASSISTANT COMMISSIONER HILTON: But under today's game rules, that is not the case.

SENATOR BASSANO: Mr. Muller?

MR. MULLER: Thank you.

I wrote down some notes about some of the roadblocks that you seem to be encountering. One -- correct me if I am wrong -- caseloads are too high.

MR. SAGER: Yes.

MR. MULLER: I picked up in your discussion a reference to inadequate treatment. Four hours a week I don't think is what you would call intensive treatment. Many inmates are not seriously involved in treatment, or are keenly motivated to be in treatment. I think the gentleman here discussed that extremely well.

Recidivism study or measureable outcomes: You were talking about some after-care needs. The assessment evaluation, selection, criteria -- whatever you want to call it -- process-- You need equipment you are lacking there.

Group therapy only: I keep hearing therapy. I would tie that in with Item No. 2, insufficient treatment, or inadequate treatment. I think both you and I could agree that group therapy, as a single-standing entity, is not necessarily the maximum modality that you wish to pursue. Also, you mentioned the inadequate attention to early intervention with juvenile offenders.

But you never mentioned the effects of drugs and alcohol. I asked the Superintendnet, early on today when we were taking our tour, "What percentage of inmates in this facility were abusing drugs or alcohol before they got here?" not after they got here. Do you have any idea what that is, and does it run consistent with the normal pattern of criminals?

MR. SAGER: I don't think it runs consistent with the normal pattern.

MR. MULLER: Higher?

MR. SAGER: I think with normal criminals, it would be a higher rate than with sex offenders. However, a goodly percentage of our people have drug and alcohol problems. Maybe, off the top of my head, 30 percent or 40 percent. Just

off the top of my head and in response to your inquiry about this, we have two substance abuse counselors who work here full-time.

MR. MULLER: You have two substance abuse counselors to work with 40 percent of the population, which is -- 40 percent of 700, about 280, so their caseload is 1 to 140.

MR. SAGER: Probably about that.

MR. MULLER: I am going to refer back to Item No. 2 that I mentioned, inadequate or insufficient treatment time. These are roadblocks. I am not suggesting it is your doing. This is just an observation from someone who is in the field.

MR. SAGER: If I might make another observation, I think a regular institution, which has a much higher rate, has even less substance abuse counselors than we do.

MR. MULLER: But that is being addressed through the Peer and Bridge, so the Southern State Correctional Facility has the Peer Program. They are working toward that now in Corrections to look at treatment, because what happens-- I am just making a statement; I am not trying to take the floor here. Drug- and alcohol-addicted people going to prison-- They may be dry while they are in prison -- maybe, but not likely -- but when they get out they return the next day to their drug or alcohol problem, if they receive no treatment. You know that.

MR. SAGER: Yes.

MR. MULLER: I know that. My good colleague, Dave Evans, knows that. So these are issues that I think need to be addressed also by this Task Force as to what support and resources we provide to you, because I think a caseload of 1 to 44 is too high, and certainly 1 to 140 is unmanageable.

MR. SAGER: I run an after-care program for the guys who leave here. One of the most successful combinations of care once the person leaves here is coming to our group and

going to an AA group, whenever he wants to -- two, three times a week -- especially when they first get out.

MR. MULLER: That ought to perhaps be something -- a requirement of parole when they complete their term, that they must attend.

MR. SAGER: It usually works very well.

MR. MULLER: "If they want to" is too discretionary.

Thank you for your time.

MR. SAGER: Sure.

SENATOR BASSANO: Assemblyman Zisa?

ASSEMBLYMAN ZISA: Thank you, Senator.

I know we have touched on this a few times throughout the course of the meeting; that is, the release of inmates on parole. But I would like to be clear in my mind as to exactly what happens during that process. By that I mean, you mentioned earlier, if I understood you correctly, that you feel you need at least five to six years to feel comfortable with treatment. But what I would like to know-- You mentioned about the three areas you look for in therapeutic treatment that you want to be satisfied with.

Specifically, what would trigger, and at what point would it be triggered, consideration of releasing an inmate? How many people would be involved in that decision? Exactly how would that process take place? About how long would it take for that process to evolve?

MR. SAGER: Okay. We have a system now where a man will put himself up for the release process. He will, in effect, say, "I feel like I'm ready," or, "I feel like I am almost ready to go home now." He will come before an in-house panel of psychologists. Approximately five psychologists on our caseload will interview him extensively and make a release determination themselves. They will take a vote at that point -- a majority vote. If he passes the panel, he will be referred to the Special Classification Review Board, which, as

I said before, is the independent panel of psychologists, experts who come in from outside to make a release determination on the same man. The amount of time between passing the in-house panel and the SCRB seeing the man should be about three months or so, to get all of our reports in, to get a parole evaluation done, etc.

The SCRB will then interview the man in a similar way, make their own determination, and then either pass the man and refer him to the Parole Board, so that the Parole Board can make their evaluation, or else fail him and have him come back into the regular prison population at that point. The man then goes before the Parole Board, which makes yet another independent evaluation to determine whether they feel this man is releasable or not. If the Parole Board feels he is releasable, he will then be given a parole date, approximately a month, a month and a half, two months from that time.

ASSEMBLYMAN ZISA: How long does it take from the time he originally made his application to the ultimate release date?

MR. SAGER: It varies. It should take about six months or so, if he passes all the boards.

ASSEMBLYMAN ZISA: If he is denied, is there a time constraint on when he can apply again?

MR. SAGER: Generally, we will wait three months before we will re-review the man. The SCRB or the panel could say, "These issues are serious. Don't come before us again for six months, or a year," depending upon what the evaluation was like.

ASSEMBLYMAN ZISA: The other thing I want to ask about is something that Senator Bassano originally brought up, and it seems like we keep coming back to it, also coupled with something the Superintendent mentioned.

If we were to change the sentencing framework structure for you to work with-- You mentioned, before, that prior to 1979 there were 30-year indeterminate sentences. My

understanding of the law, if I am correct, is that a person could commit a very high level offense and still be subject to, maybe, only a 10-year maximum sentence. If we statutorily were to go back to when a person is adjudicated to be a repetitive/compulsive sex offender, and reestablished a 30-year indeterminate sentence, do you feel that would give you a lot more leeway, especially addressed in terms of protecting the public in cases -- as the doctor mentioned -- when you feel a certain individual or a certain percentage of individuals cannot be rehabilitated, and cannot be successfully treated? At least they would be kept off the street for 30 years, which is considerably different than a person, as we talked about, being transferred and being released in a relatively brief period of time. Do you think that would be helpful to you?

MR. SAGER: That is probably an important question. Maybe both of us can answer it, but from my standpoint, from a therapeutic standpoint, it makes sense for two reasons:

Some people, we know, are very dangerous. Some people, we know, do not make much progress in treatment and feel very uncomfortable about letting go. So that type of person-- You would give us another tool. You would allow us to keep that man a lot longer.

The other reason why it makes sense is -- it makes so much sense to keep these guys in an after-care program for a long period of time. If we had 30 years on the back end, we could let the guy out after five years, if he did real well, but still have a long time to have him continue in therapy on the street, with continued supervision with the parole officer.

So for those two reasons, it makes a lot of sense from my standpoint.

ASSEMBLYMAN ZISA: I think something else also addresses the concerns I overhear: If a space in this facility is being taken up by a person who refuses to participate, has no intention of participating in the treatment, and is shipped

to another facility, that opens up a space here. But when you are facing a 30-year sentence, I think there is no reason why, after 10 years or so, if an inmate makes application from another facility to be relocated over here-- Perhaps you could also take a look at that down the road. You might be able, if an inmate initially refuses treatment, whether it takes 5, 10, 15, 20 years for them to realize that they are not going anywhere, and perhaps their only alternative is to seek treatment--

I think that might really address a few of the concerns. Mr. Plantier, do you want to comment on that?

MR. PLANTIER: Well, I certainly think there are a number of ways to do it. We certainly like the concept now of the new law that requires -- that allows us to take away their working commutation time for not fully participating in therapy. I would think -- although we have not yet seen it; it was just signed yesterday -- that that will have a motivational effect on the therapy refusals. I would like to see how that works. Maybe in combination with that, instead of going back to indeterminate sentencing, you just maintain the determinate sentencing, only make it the maximum allowable for a particular crime, instead of giving the judges the leeway. Then, at that point, maintain the law that we have now about taking away the good time if they do not do things to deserve it. That may be a cleaner way to do it.

I certainly see nothing wrong with talking about trying to take the man who is sexually dangerous and confining him for the longest period possible. You know, if that means changing some additional laws, or what have you, I don't think there is going to be any disagreement from anybody, us included, because we know how sexually dangerous some of these guys can be, and we keep them as long as we possibly can.

So anything along those lines that is going to prevent that guy from getting out, whether it be taking credits, giving

him a longer sentence, or if he does get out, putting him on lifetime supervision. A parole mandating therapy is part of that lifetime supervision -- mandating after care.

All of those things are things we are talking about doing also, and I think fit very nicely in with what we would like to do as a Treatment Program.

ASSEMBLYMAN ZISA: Thank you.

SENATOR BASSANO: Do you have a comment back there?

ASSISTANT COMMISSIONER HILTON: (speaking from audience) Yes. I think if you are thinking of the 30-year indeterminate, and I think if you are thinking in terms of people who, after a reasonable period, are transferred to a traditional prison, I think it has to be combined in your law that if they get transferred to the traditional prison, they do every day of that 30 years, with the only way out being this place.

SENATOR BASSANO: Absolutely. I said that earlier.

ASSISTANT COMMISSIONER HILTON: Otherwise, you are going to have an exodus. They are going to play the "Yes, sir/no, sir game," and get pulled out of the traditional prison.

SENATOR BASSANO: I said, earlier, that the only way to get out would be through your front doors.

ASSISTANT COMMISSIONER HILTON: Or you do the whole 30.

SENATOR BASSANO: Yes, or the whole 30.

ASSEMBLYMAN ZISA: That is what I meant when I said an inmate could conceivably sit in a regular facility for 20 years, and at some point determine that he is doing the 30 years unless he is cleared through this agency.

MR. PLANTIER: There are men in this facility right now who have served 25, 30 years of their sentence under the old code, you know, who are approaching their maximum under the old code, and they have not gotten out. So clearly when we have the ability to hold someone and we find him dangerous

sexually, we do so. We don't play it fast and loose. Nothing ever seemed to be gained by doing that. So we will hold them.

ASSEMBLYMAN HOLZAPFEL: I think the old system used to be a sentence -- or indeterminate terms used to be a sentence based on the person. We changed the code. Really, it is a sentence now based on the crime. What you are saying is, maybe what we should do is, yes, have a system under the code where there is a sentence based on a crime, except where you are dealing with sex offenders. Then we should deal with a sentence based on the individual and talk about indeterminates so that-- You are really talking about treatment as opposed to -- unlike any other criminal who comes through the system, possibly being drug related.

Normally, we are talking about possibly an indeterminate sentence for sex offenders and the rest of the code remains the same, meaning the crime gets you "X," forget what you are or how you did it. If it is a first, second, or third degree crime, this is what you are going to get.

ASSISTANT COMMISSIONER HILTON: I think clearly the extended indeterminate sentence really grabs at -- in my judgment anyway -- the best element of public protection, because if nothing else-- If you can't treat them -- and I think these gentlemen have suggested that there are people that can't be treated -- you can at least incapacitate them for a period of time.

SENATOR BASSANO: We ought to ask that question, because I believe there are some people you can never treat. You are the expert. Tell us whether that is so or not.

MR. SAGER: I guess it goes against my grain as a psycologist to just automatically go like that, but there have certainly been a number of people I have come across that I have not been able to treat over the course of a number of years. So you are probably right.

SENATOR BASSANO: Mr. Evans?

MR. EVANS: Before I opened up my law practice, I used to run the State's Drunk Driving Program. I know what it is like to get a lot of attention from the press and from legislators who want to hear that clients go out and do something terrible. So you have my understanding.

One of the things I was concerned about was attitude. When I was running the Drunk Driving Program, I saw that the purpose of that Program was public safety. Although I treated many thousands of drunk drivers every year, it was, number one, public safety. I would assert that a role of this institution is to protect my children, not to treat sex offenders.

Also, we seem to be struggling with the issue of money. I can see a couple of different ways that we can get money to provide more treatment. I am doing this, again, based on my own experience with the Drunk Driving Program. I got the money from the drunk drivers. You know, I know people who have been victims of pedophiles. Some of them don't have the money to pay for therapists, and a pedophile may very well be here getting free treatment from the State. I think the pedophiles ought to pay for it. I understand that most of your inmates are pedophiles.

I would suggest to the legislators that they might want to impose additional fines on anybody convicted of any sexual offense, and that that money go into a special account, as it does with drunk driving. Drunk drivers have to pay. In my six years of administering that Program, I made a profit for the State every single year, except for one year, and then I had surplus funds to make that up.

I got a lot of grief when I wanted to have the drunk drivers pay for it. People said, "Well, they can't pay for it. There are a lot of poor people," and so forth. But they came up with the money, believe me.

I think extra fines ought to go in for sex offenders to go for treatment, not only sex offenders, but treatment for

the victims. I would suggest to you, also, that it is very helpful for your staff to meet with victims' advocacy groups. I learned a lot from them. We use victims in treating the drunk drivers. Now, I realize it is a very sensitive issue, and it has to be handled properly.

MR. PLANTIER: We do do that.

MR. EVANS: Right, I understand that. But I learned a lot from the victims. It helped me to keep my objectivity about what I was doing and not to overidentify with the offender, but to start identifying with the victim a lot more.

Fines: We could forfeit any assets that are used. If they use a car as part of their criminal activity, the car can be forfeited and sold. If they use a house, the house can be forfeited and sold. They should be made to pay. Anybody who benefits from treatment, even if they don't have the money-- You know, I used to be a public defender. Nobody who went through the public defender system received free help. They all had to sign liens if they didn't have money. Liens could be put on these people. If treatment helps them to get their lives back together, and they can go out and lead a normal life after this, they ought to pay the State back for their treatment. The State benefited them, and they should pay for that benefit.

I am also a little concerned about the conditions here. It has been a while since I spent a lot of time in prisons. I used to. The conditions here seem to be better than they are at the average prison. Is that true or not? I see that a lot of the people here have their own TV, and computers, and all kinds of things. Is that the way it is all over the system now?

MR. PLANTIER: It depends on what type of facility you are in. Obviously, there are different ages to some of the facilities, and you are not going to look like this. We certainly pride ourselves on trying to keep the institution up

and in good shape. I think we do a fairly good job for a facility of this age, with this many people.

In terms of inmate possessions, we have basically the same as other facilities -- adult, long-term facilities would allow in. In terms of computers, they are allowed to have their own personal computers if they purchased them, under very, very strict guidelines. In terms of radios, you are allowed to have a radio. In terms of a TV set of certain size, yes, they are allowed to have them if they purchase them and bring them in through source of sale. So there is nothing that is unique in terms of the population, in terms of the things they have.

MR. EVANS: So they do have money, then? I understand that some of them are former teachers; that you even have a couple of doctors in here.

MR. PLANTIER: Yes, we do.

MR. EVANS: What would you think of an effort to make them pay for their own treatment? You know, if we got $1000 -- I don't know if it is possible to get $1000 from each one of them -- that is $700,000, almost half of your treatment budget.

MR. PLANTIER: You know, the issues of fines and restitutions are something that certainly the courts can take up. Obviously, if a person is in a better position to pay those fines, then they should be high. But you run the gamut with the people in the institution, in terms of people who may have had money and the people who had absolutely none, with the bulk probably falling somewhere in-between. I don't think there are a heck of a lot of people here who, by the time they got in here, had a heck of a lot of resources left that weren't tied up with a family, if they still had a family. That is my impression.

MR. EVANS: But what about the victims? The victims may have even less resources.

MR. PLANTIER: Well, certainly, but I cannot speak for the victims. That is obviously not my role. Most of the men here do have a fine to the Violent Crimes Compensation Board, and it varies considerably, the amount of money they pay. Hopefully, that is to go to the victims.

In terms of having them pay, I would think that it would probably be more simply done at the level of fining the person at the time of sentencing. That is where a more complete understanding of the person's financial situation will be developed as part of the probation department report, the presentence.

MR. EVANS: What do you think about liens? We make people pay for student loans. We send people to college to benefit, and they have to pay us back. What about making them pay when they get out of here? It might be good therapy.

MR. PLANTIER: I don't know if I really have a strong opinion on it, because I don't think I know that much about it, or about how it actually could be accomplished. Okay?

MR. SAGER: If I may just say something about that, I certainly would have no problem with having them pay for their victims' therapy before they buy their first computer here. There is no doubt about that. That makes a lot of sense. They would have more time to write in their therapy books if they spent less time working on their computers.

We work with victims' rights groups, and the Rape Crisis Centers come in here and talk to us, sometimes bringing victims in. I am struck with the idea that I think they struggle with their funding. They really do not have enough money for treatment for victims, and that's not right. The victims should get treatment before our guys get treatment. I don't think we have any problem with that.

The one thing I think we do need to look at is, if they are going to pay for their own treatment while they are here, it might give them one more incentive to try to avoid

coming here, to try to avoid treatment. If they had to pay for treatment here, or else go to a regular prison and not have to pay anything, that might not be what we want to do. We might want to be encouraging these guys to come for treatment. So you should look at that.

MR. PLANTIER: The other issue there becomes quite clear. We have issues now with some of the guys who do have money, who have basically taken us to court at times, saying they want their own therapist. "If you want me to do treatment, fine, but let me hire my own therapist to come here to treat me." Obviously, the Department has taken the position that clearly that is inappropriate: "The treatment is going to be provided by the Department of Corrections. It is not going to be provided by you paying your own therapist."

MR. SAGER: Because then you would just get the--

MR. EVANS: I would suggest that by committing the offense, they lose their rights. They lose their right to choose a therapist. They should be made to pay for it.

MR. PLANTIER: Well, that would be the next thing I would see coming out of that.

MR. EVANS: It might be a good idea to just have somebody working on that. I had somebody working on it almost full-time, collecting money from drunk drivers. That is what he did all the time.

MR. PLANTIER: We have just made a major initiative in the Department to collect the fines that are outstanding. That is in all the institutions, but here as well. We are making a major effort to get those fines paid prior to their release.

SENATOR BASSANO: Senator Matheussen, I think, was next.

SENATOR MATHEUSSEN: I know the hour is getting long, but I do have--

SENATOR BASSANO: John, just let me entertain one fast question on the subject we were just on.

ASSEMBLYWOMAN TURNER: I was going back a subject. I wanted to ask you, Mr. Sager, about your procedure for determining readiness of the inmate to return to society. Earlier, you said the first step is for the inmate to say he is ready to go back to society. Is that correct?

MR. SAGER: That is the first step in the procedure, yes. The inmate will initiate the release process himself.

ASSEMBLYWOMAN TURNER: Okay. Well, I read this in the paper, so I do not know if it is true. But one of your more notorious former inmates, which promulgated the package of bills that were just signed yesterday-- In the paper, it was indicated that he, of course, did not undergo treatment, because he opted not to. But he also said that he wasn't ready to return to society. Now, is that true? Then he was released.

MR. SAGER: I read the file. I think he might have said that after the fact -- after he got out. Maybe Mr. Plantier knows. I don't remember reading that in our file, that he had said that before he got out.

ASSEMBLYWOMAN TURNER: It was in the paper. I don't know who revealed that. I was just astounded that he said he wasn't ready to return to society, and yet it was released.

SENATOR INVERSO: Mr. Chairman, he maxed out, didn't he? He maxed out.

SENATOR BASSANO: He maxed out, so there was no way you could keep him here. He fulfilled his sentence.

SENATOR INVERSO: He did say he was concerned about his future, but he maxed out. Legally, they had no way to retain him here. If we had civil commitment and that kind of thing in place, maybe we could do some other things.

MR. PLANTIER: If he had been that concerned about his future and that concerned about his therapy, he certainly was well-aware that he could have returned here at any time to after care as often as was necessary, and he would have been seen. So, you know, I don't know whether I can attribute that

statement to him or not, but I certainly think if that is what he said, it is certainly not what he did.

ASSEMBLYWOMAN TURNER: But if somebody says they were not ready, do you just push them out anyway? You don't refer them to another institution?

MR. PLANTIER: No, no. If a person has completed his sentence, as the law stands, and he is not commitable civilly, then they have to go. That was certainly the situation with Mr. Timmendequas. Now the commitment laws have changed again as part of this package of bills, and there will probably be more leeway in terms of civil commitments. We will have to see, I guess, over time how that works out, because it is brand-new and we have not attempted to commit anyone under it.

The current situation that existed in 1988, when he was released, there was no issue of civil commitment. He was certainly advised that he could go to after care if he so chose, and neither of those things happened.

ASSEMBLYWOMAN TURNER: Thank you.

SENATOR BASSANO: John -- Senator Matheussen -- I interrupted you. Please continue.

SENATOR MATHEUSSEN: I have viewed what we have done here, since the whole history of Avenel has somewhat given you a "Mission Impossible." From your own testimony, that mission was to try to bring some form of a, if not a cure, at least successful treatment to people who had been convicted of deviant sexual crimes. Your own testimony is that very few are cured. To that, you hold yourselves out, to some degree, to public scorn and public criticism, because you cannot complete the mission that we have given you.

It is obvious that that is a concern, but it is not a concern so that one should set up an adversarial proceeding. That is not -- at least not what I envision -- our purpose for being here today. I think, really, what we are here today for-- Perhaps those of us sitting on this side of the table

have a role and a priority. That priority probably is public safety, as I am sure your concern is, too. But your role in the scheme of things is, obviously, to work here and evaluate and treat people who are patients at Avenel.

Keeping with that, I have a criticism. From that, I don't want to make this, or continue this in any way, shape, or form as an adversarial proceeding. The criticism I see has been mentioned by a couple of people around the table; that is, the vital time I saw. I saw patients, or prisoners, in bed watching television, working on their PCs, when, in fact, perhaps more busy time could be provided. That might not be your responsibility or your fault. Perhaps you do not have the resources to do that, but I think we should reach out for those resources and come to terms with it.

You have been asked several times -- and perhaps today is not the end of it, but I think it has to remain a constant give and take -- "What more can we do to make your job better, or to make your job easier? How can we go about trying to bring some form of control over what it is you do here? Is it more resources?" I am not expecting any more answers than you have given today. You listed five items, before: more therapists, more after care-- After care seems to be a very important proactive part.

Other than the idleness, there were some statistics that you provided for us. They gave me some concern. What is the average stay, or treatment program for a prisoner who is assigned to you? What is the average amount of treatment, in terms of years, that they would need in order for you to say, "We have had some degree of" -- either measuring in success, or measuring success? How long of a time would you say?

MR. SAGER: Okay. This is a real assumption on my part. I do not have anything to really base this on, other than my clinical experience. I would say that four or five years, usually, would be the amount of time -- would be the

average amount of time where the person could reach a point of diminishing returns in terms of what he responds to in therapy. Some men a lot less time than that, two or three years probably. Other men could use more than five years. But probably five years for our type of inmate who admittedly has serious character flaws and serious problems. That would be a good time for them to then go back out on the street under good supervision, with good after-care treatment.

SENATOR MATHEUSSEN: Would you help this Task Force design a good after-care program? I mean, do we have that in place now? Do we need to put that in place?

MR. SAGER: We are in the process of doing that, and are making it better all the time. Over the past two or three years, we expanded from an after-care program that just met here in the institution. Now we have meetings at three different parole district offices, in addition to this institution. So we are expanding to other parts of the State. We are tying into our Relapse Prevention Program here, so that the paperwork that they begin to do in the Relapse Prevention Program goes to the after-care therapist, goes to the parole officer, and there is a continuum of care going on now. So we are in the process of improving-- I guess I am saying we are in the process of improving it, right?

SENATOR BASSANO: I think you ought to point out, though, that as long as we are allowing people to max out, you cannot mandate that they be in an after-care program. It has to be a part of their parole.

MR. SAGER: Not only that--

SENATOR BASSANO: That is why parole is so important.

MR. SAGER: --but every time we have a group of maxed out people, a therapist will go and say, "Here is where the after-care programs are. It is a great idea for you to go. You really need it." We will get one or two out of twenty who take us up on that, and the others we don't see anymore.

SENATOR MATHEUSSEN: I think what Senator Bassano said in the very beginning, making that part of a mandatory program, is absolutely essential to any degree of success in trying to make your mission impossible a little bit less impossible.

The other thing, though, that hit me, and then the statistics gave me more concern-- You gave us a tour today. We went to one cell where there were three elderly gentlemen. I thought to myself that it appeared from their physical abilities -- or inabilities that their being incarcerated here at Avenel seemed almost an inappropriate use of resources. I am asking you to help us, and Senator Inverso has asked you, I think, very clearly, "What else can the Legislature do to make your job better?" But some of the things that I see at Avenel right now-- Is there a need, for instance, those three elderly inmates we saw, and maybe there are more-- Is there a need for them to be here, or are we not making good use of our resources at Avenel? Could they be someplace else, perhaps filling out a finite amount even if a life sentence of punitive nature, but yet in a less secure institution, where other people could be treated here at Avenel? Do you have a response to that?

MR. PLANTIER: I think that is a good point, but there is nothing in the law -- in the legislation now that--

SENATOR MATHEUSSEN: Remember, this is not adversarial. What we are trying to be is proactive here. I am seeking your help so that we can do a better job.

MR. PLANTIER: We question the same thing sometimes. These guys that you saw who are old are typically not guys who have been in this institution for 20 years either. A lot of them have just come in. A lot of times, the age at first incarceration is going to be well into the 60s. There are guys who have committed sexual crimes of fondling, touching, for the most part against their grandkids or other kids in the neighborhood. They are very much regressed child molesters and pedophiles and share very much the same problems as a lot of

the younger guys, only they experience their difficulties at a much older age. For the most part, they are not career criminals who have come up through the system all the way through and now have just reached this age with their last crime.

SENATOR MATHEUSSEN: For the most part, will they ever leave Avenel alive?

MR. PLANTIER: We have quite a few of them die while they are in the facility, based all on natural causes. You know, we kind of have quite a few of them, just based on the age that they first come in. Whether treatment at that age is appropriate or necessary, or they would be better off at a less secure facility-- That is a damned good question; it really is. I don't pretend to know the answer to it, because-- The only thing I can say in those cases is that the judge always reserves the right to not sentence them here, even if we find it to be repetitive/compulsive. So if the judge felt he should not be in treatment, then the judge could have always said, "No." I will go back to it again, the fact that we like to do our best to the extent possible to honor the judge's wishes in terms of carrying out his sentence.

ASSISTANT COMMISSIONER HILTON: (speaking from audience) I would like to make one comment, if I may, Senator, regarding after care. If, in fact, you are successful in curing whomever is released, that person is released under some kind of parole supervision. Clearly, it would be the Department's point of view that we ought to move toward specialized caseloads. Certain caseloads would be totally sex offender caseloads, where the officers would be specifically trained, and would network with the institution. Obviously, that carries a fiscal note -- more officers -- but to make the package solid, specialized caseloads are very critical.

SENATOR MATHEUSSEN: I don't disagree. The statistics also-- The Adult Diagnostic number of inmates, December 31,

1993, was approximately 670 inmates. Forty-seven, or 7 percent, were over the age of 60. Now I am not saying 60 is a cutoff age where someone might come to the point of being infirm and really is not a danger or have a reason to be here. But I don't know what those 47 -- what the terms of their sentences are, which would be an interesting statistic to see. If they are over 60 and the term of their sentence is 15 years, it seems to me that that might be an inappropriate use of Avenel's facilities for that particular inmate.

The other statistic is: Those inmates who are serving over 15 years, 16 and above, number 196. That is 29 percent of your population serving more than 15 years. You, yourself, have said that probably two, three, or five years is the amount of time for the treatment that is necessary. Are we not misusing, then-- Again, I am not being critical of you; I am being critical of us, all of us, the system. Are we not perhaps misusing the facilities of Avenel for incarcerating people for more than 16 years? I don't even know if they are spending it all at Avenel. Is there a better place to put these inmates than using the facilities at Avenel and using up your precious resources for treatment?

SENATOR BASSANO: The one thing we haven't talked about-- Maybe you ought to mention the number of people on the waiting list -- people in the county facilities waiting to get in here. So the point that was made was a valid point.

MR. PLANTIER: At present, this week, the waiting list stands at 73. As I mentioned, at least in my group as we were going around, on wings seven and eight, the new housing units, we have created a series of dorms out of study rooms. Actually, effective tomorrow, we will be starting to take in another 25 inmates to bring that waiting list down. The population will go to about 740 inmates at some point -- at the end of next week, I would assume. So, yes, the waiting list continues to grow. We see no particular end in sight for it.

The last departmental figures I saw -- a few years ago -- showed us basically the population approaching 1000 by the end of the decade. So, you know, you are not going to see, really, an end in sight in terms of this.

SENATOR MATHEUSSEN: No, but perhaps by at least selecting some of those inmates who do not need to be here out, we can make it more available to those who might get some progress out of the system. I think we need to work together to try to deal with some of e numbers we have.

MR. SAGER: Out institutional approach to the law has been very straightforward. We have two psychologists downstairs who will look at every case and, regardless of any other factor, determine whether that person is repetitive/compulsive or not, in their opinion. If they are, they are put under the Act. If they are not, they are not put under the Act, whether they are 90 years old-- There is a host of other reasons why we would not be able to treat him. We are just reacting to the law as it stands now. So that would mean an adjustment to the law, probably, if we were going to do something like that.

SENATOR MATHEUSSEN: One last thing, too. It goes back to the first comment I made before about a criticism; that is, the idleness. Those inmates who are able to earn money certainly could be putting that money back into the system for their own treatment, or for the treatment of victims, as opposed to needing, perhaps, as many TV sets as we saw out there today, and whatnot.

I am not trying to grandstand on that issue, I'm really not, but it seems to me that that is an awful waste of resources.

SENATOR BASSANO: Are there any other comments? Before I call our last speaker, Dr. Brooks, Senator Inverso has one question.

SENATOR INVERSO: I hope it is clear, anyway, that we are trying to approach this from a big picture assessment in terms of the mission, how well it is being accomplished, what we need to do to get it accomplished better, and what we do after the inmates leave here.

However, I couldn't help but make a note going through the facility on one area, where we talk about the need for resources. We went into the area where the art work drawings were displayed. I am just curious. The individual who runs that program-- Is that individual a therapist, a psychologist, or just an art teacher?

MR. PLANTIER: An art teacher. She has been with us pretty much since the program started. All arts and supplies are paid for by the inmates themselves.

SENATOR INVERSO: What about the teacher's salary?

MR. PLANTIER: The teacher's salary is paid for by the State of New Jersey, Department of Corrections.

SENATOR INVERSO: I am a supporter of the arts, okay? I find that hard to accept. I know individuals who can't give their children art lessons, because they can't afford it. Why would we pay the salary of someone to teach art, even though the supplies and everything else are paid for internally, when you are short therapists, psychologists, and counselors?

Again, I don't mean to get microscopic and, as Senator Matheussen said, we are not looking to emotionalize or demagogue an issue. But it seems to me that when we don't have the money to do a study statistically of what our recidivism rates are in order for us to have some measurement to make an evaluation of how well the mission is being accomplished, to take money -- and I don't know if it is $20,000, $30,000, $40,000, or $50,000-- It seems to me that that money could be diverted to either the statistical compilation of recidivism experience, or counseling. I just wanted to go on the record as saying that, because that troubles me.

MR. PLANTIER: Well, I think, as any institution, we have a wealth of leisure time programs. We do not have many here. We are a small program. We only have three academic teachers in the entire facility for a going-to-be 740-inmate population. The art room has been extremely heavily utilized as a recreation program, as well as an educational program since the inception of the facility. It has really been a part of us. You know, by the same token, we have recreation supervisors and assistants who run a full range of recreation.

You know, I can certainly agree with the point you are trying to make. I think, though, that we have to have things for them to do in terms of leisure time activities, things to help them to grow in other directions. I don't think there is a heck of a lot of money being spent in those areas.

SENATOR INVERSO: I don't mean to debate this, and I don't want to be adversarial or controversial. I think you know that. But when you are looking at priorities, and you are looking at four hours or so a week of counseling, which strikes me-- Again, I don't have any expertise in this area to measure whether the intensity of that is just about right or should be more. But it strikes me that there is some kind of imbalance there relative to money going to an art teacher, as opposed to a counselor, when you have one counselor, or therapist per 44 inmates.

You know, I realize we have been cutting back, but somewhere there has to be some realignments. I understand that expression through an art form helps many times with the ability to deal effectively-- I understand that, but maybe you could achieve the same thing by giving someone paper and a crayon, or a pencil, as opposed to having a full-time art instructor on board.

ASSEMBLYMAN ZISA: If I may, and just keeping in line with that, one of the questions I had during the tour-- You couldn't help but notice the very close and contained living

quarters of the inmate population. One of the things that struck me, and I asked about it during the tour, was: What is the incidence of violence, or physical confrontation that might occur, you know, during any given time?

What I am wondering, and I certainly understand the point of trying to take away the perception of a country club type atmosphere-- I am wondering, if you didn't provide activities like that, or you didn't allow inmates to spend time watching TV or working on a personal computer, do you think that might result in having more idle time, thereby, perhaps, increasing the possibility of conflicts, and in the end resulting, perhaps, in the hiring of additional security guards, or staff who would be responsible for controlling, maybe, the higher incidence of violence? I don't know.

MR. PLANTIER: In a word, I would absolutely agree with you. Programs for inmates, whether they be educational, vocational, or recreational-- Certainly, when you talk about overcrowded facilities, the more programs, the more you can keep them busy, the more you can keep them involved in activities, clubs, or organizations, I think the less problems you have with violance or assaults against your staff or the inmates against themselves. So, certainly, when you start taking away all those things, those things that basically help them through the day, you certainly are talking about things that could cause potential violence within the institution, especially when you are that crowded, with people living right on top of people.

ASSEMBLYMAN MIKULAK: Real quick, Bill, how many escapes have there been in, say, the last decade?

MR. PLANTIER: Oh, that is the kiss of death. In the last decade, I do not believe there has been--

MR. SAGER: Zero.

ASSEMBLYMAN MIKULAK: Zero?

MR. PLANTIER: Zero.

ASSEMBLYMAN MIKULAK: You have a secure facility.

SENATOR BASSANO: Our last speaker will be Alexander Brooks.

PROFESSOR BROOKS: Well, I am not so much a speaker as someone who wants to ask some questions.

Obviously, there is an undercurrent here that has not been expressed, except indirectly, about skepticism concerning treatment. One of the issues might be the notion that if you force people into treatment, or somehow wait for five years until they accept treatment, or threaten them into accepting treatment, that they will have to go to prison, or some other sanction will result if they do not accept treatment, in the face of a great deal of literature indicating that enforced treatment or threatened treatment simply does not work, even if we assume the treatment works otherwise-- How do you respond to that kind of skepticism which says you don't have any recidivism data, which is the only kind of data that guarantees some notion of the effectiveness of treatment?

Have you ever, for example, interviewed and examined recidivists who returned here to find out whether the therapist thought they were okay when they left, but they went out and promptly committed other sex offenses? Have you tried to figure out how they managed, if they did, to fool the therapist? There is enormous literature on the extent to which sex offenders, and other offenders who are in treatment programs, give to the treatment personnel what the treatment personnel want to hear.

MR. PLANTIER: That's very true.

PROFESSOR BROOKS: I have heard no real skepticism yet around this table about that. I think there are some very, very deep underlying questions here that this Task Force should be paying more attention to, and that you should be more responsive to. In other words, persuading those who may be skeptical that, in fact, treatment does work. I think,

perhaps, I expressed-- I know at least one or two people here who seem to share this attitude, you know, that there is a given here on the part of staff. You know, treatment works. We don't have the data, we don't have anything else. Just take it from us, treatment works. An enormous amount of money is being spent on it, and we are just assuming that people who persuade us that treatment has worked for them are okay to release into society.

That is the main point I want to make, mainly that I would hope that this Task Force would pay more attention to that, and that the staff would pay more attention to persuading the Task Force in what way treatment does work, how effective it is, and so forth and so on.

MR. SAGER: Well, I think your comments take me back to my initial statement about responsibility and whether or not the inmate is taking responsibility or not for what he did. I think someone who fails to take responsibility for what he did is a coerced client. That is where statistics usually come from that the therapy doesn't work.

PROFESSOR BROOKS: May I interrupt only to say that you are going to get a very small percentage of people who are so warped that they are going to refuse to take responsibility. I know there are such people, but how many sex offenders will say, "Sure, I'll take responsibility. It was wrong. I shouldn't have done it," and so forth and so on? The therapist says, "Great, we have broken the first barrier. Let's go on to the next." There is enormous literature on conning.

MR. SAGER: My response to that is: Your first step would be to hire good people, because people who know sex offenders, who know inmates, are a little bit less likely to be conned than people who don't. So that, first and foremost, would be the first step you have to take.

The second step you would have to take would be a victim empathy group. What has been found, especially over the past five years in victim empathy, is that sex offenders go into a victim empathy program and do not have empathy for their victim. What needs to happen is to give them an opportunity to talk about if they have been victimized over a certain period of time. Accept that, accept their victimization.

PROFESSOR BROOKS: And that works?

MR. SAGER: Put them in a position where once someone accepts their victimization, they are much more likely to accept what they have done to someone else.

PROFESSOR BROOKS: How do you know that that works?

MR. SAGER: Statistics have shown that victim empathy groups have a lower recidivism rate than people who do not take victim empathy. It is a very difficult question to answer. To a large extent, it is clinical judgment, and you know clinical judgment is something that is hard to put your finger on, and not very reliable. So what we have to do, actually, is take a number of years and see how it works as time goes on. Up to this point, it works well. Logically, it seems to make sense. The men certainly seem to change dramatically if you have them in that type of a group.

I don't know if I can answer the question any better than that.

PROFESSOR BROOKS: Well, later I will ask you for any research findings you may have.

MR. SAGER: We certainly have them.

PROFESSOR BROOKS: I would like to get them from you. I did mean to get a package.

MR. SAGER: We will see that you get one.

ASSEMBLYWOMAN CRECCO: I think that would go back to-- If you had staff and equipment here for a proper database, you could get these results better, and know exactly

what is working and what is not. This is probably very important for you.

MR. SAGER: No doubt about it.

SENATOR BASSANO: I want to conclude today's meeting by thanking both of you gentlemen for being here. I think we learned an awful lot. There are still a lot of questions in other areas that we want to have answered. We hope to be able to work with you to make the system work better. I think we are on that road now and moving in the right direction. We may call upon you again, but we do thank you for allowing us to be here and for the testimony you gave.

MR. PLANTIER: Thank you.

(MEETING CONCLUDED)

APPENDIX

August 1994

SUPERINTENDENT'S STATEMENT

The Adult Diagnostic and Treatment Center (ADTC) was opened in 1976 to provide psychological treatment to convicted male sex offenders as stipulated under New Jersey's Sex Offender Act. The treatment program has grown from 6 full-time therapists, with an average case load size of 20 to 16 full-time therapists with an average caseload size of 44.

The primary treatment modality is group psychotherapy. Each inmate is assigned to a primary group. The average primary group size is 12 to 20. A variety of ancillary groups focused on specific issues such as victim empathy, anger management, social skills training, and relapse prevention are also available. There are a total of 11 ancillary groups, involving a total of 215 inmates at one time. In addition, there is an active peer counselling program under close staff supervision. This program includes a total of 170 inmates in 14 groups which focus on various aspects of sex offender problems, including rape, incest, and pedophilia. Finally, there is an extensive substance abuse program offered by the Social Services Department that sponsors 5 self-help (12 step model) groups and conducts 6 psycho-educational groups focused on various aspects of alcohol and substance abuse.

Current needs of the treatment program include restoration of frozen therapist positions in order to reduce the high average caseload size (44). This would permit more individual therapy to be conducted, an important but now rare treatment component. Additional staff would also be required to:

1. develop and operate a research/recidivism component to help monitor program effectiveness;

2. augment the Aftercare Program which is a vital element to successful community reintegration;

3. resume Sex Education groups that were discontinued in 1992 for lack of a qualified professional to coordinate this endeavor.

Other needs are for a penile plethysmograph and polygraph to supplement behavioral reconditioning training.

Revised: August 21, 1994

ADULT DIAGNOSTIC AND TREATMENT CENTER

HISTORICAL OVERVIEW

In 1950, the original New Jersey State Sex Offender Statute[1] went into effect and, almost simultaneously, the New Jersey State Diagnostic Center, Menlo Park, opened.

The Statute mandated the examination of all convicted sex offenders, and also mandated treatment for those found to fall within its purview. The major criteria were that repetitive and compulsive behavior be found (and this became the prime determinant) along with either violence or age disparity between the victim and the offender.

If placed under the Statute, the Court had no discretion in that the individual had to be sentenced to an indeterminate sentence, not to exceed statutory limits for the act committed. He was then committed for treatment either to an outpatient program with probation or to an inpatient program.

Initially, sex offenders were sent for inpatient treatment to one of New Jersey's major mental hospitals, which were divided into minimum, medium and maximum security institutions. Treatment there ranged from chemotherapy to shock therapy, and some individual and group contacts.

In 1966, as the result of a legislative inquiry, sex offenders were removed from the state hospitals, except those who were overtly psychotic and/or dangerous to themselves or others. They remained at the Vroom Psychiatric Unit in Trenton Psychiatric Hospital. The remainder transferred to a unit at State Prison, Rahway and were housed and treated there from March 1967 to February 15, 1976, when the ADTC opened. It was built at a cost of 7.2 million dollars and was funded by public bond issue. The ADTC was specifically designed for treatment from its inception and was one of the first institutions built in the United States specifically for the treatment of convicted sex offenders. ADTC is the most therapeutically oriented of New Jersey's correctional facilities.

Effective September 1, 1979, the New Jersey Code of Criminal Justice was revised. Some changes affecting the sex offender statute include: a determinate sentence for each offense, eliminating the indeterminate element in the original statute; earned time credits (work and commutation time) which did not exist in the original statute; and in general, briefer sentences for similar crimes committed under the old statutes. The 2A-sentenced offenders remained under the provisions of 2A Criminal Code.

Of significant impact is the New Jersey State Supreme Court decision, State v Chapman, in which the Court stated the imposition of mandatory minimum sentences is not inconsistent with the treatment provisions of the 2C Sex Offenders statutes. Thus, an offender must be retained in custody, unless the Commissioner moves for modificiation of his sentence, until completion of the period of parole eligibility despite his therapeutic progress.

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[1] NJSA 2A:164:3 through 13 inclusive

Pursuant to NJSA 2C:47-1, each offender convicted of the specified offenses must be referred by the Court to ADTC for physical and psychological examination. The offender is either escorted or, if on bail, reports to ADTC for the one day testing and examination. In accordance with 2C:47-2, a written report is forwarded to the Court with the results of the examination.

The inpatient service component offers treatment via a multimodal concept as described in the attached separate document.

Referral to the State Parole Board is dependent upon positive recommendations from the Treatment Staff and subsequently the Special Classification Review Board (NJSA 2C:47-5).

Post-release treatment services (Multimodal Relapse Prevention) are an integral part of the sex offender parole program. These follow up sessions make it possible for staff, the Special Classification Review Board, and the State Parole Board to release offenders with the knowledge that an aftercare program is available. The treatment is by group, individual, and/or, on a selective basis, couples-family techniques.

Informative presentations are conducted for college and nursing students, professionals from criminal justice agencies and victim's program and other community volunteer groups.

In July 1980, the Commission on Accreditation for Corrections granted the ADTC a three year accreditation award. This acknowledges that the ADTC has complied with the standards for adult correctional institutions issued by the American Correctional Association. The ADTC was the first accredited correctional institution in New Jersey. It was reaccredited in August 1983.

There are presently 107 civilian and 217 custody staff employed at the facility.

An additional 304-bed dormitory housing unit was opened in January 1990. As of August 1994, there are 703 inmates in-house with a maximum capacity of 714 inmates.

ADTC TREATMENT PROGRAMS

The program of treatment designed, constructed and offered by the treatment staff is intended to approach the inmate and his problems from many avenues. The intention is to utilize many techniques that will reach and help to resolve the specific pathology of each individual. The specific program in which an individual inmate becomes involved is the result of a treatment plan initially begun by the treatment staff and then mutually agreed to by the inmate and his primary therapist. The various treatment program components currently active at the ADTC are as follows:

GROUP THERAPY

When an inmate arrives at ADTC, he is introduced to the treatment staff who interviews him in terms of background, education and experience. Based upon this review, the inmate is assigned to a primary therapist. The primary therapist in turn assigns the inmate to a primary therapy group. All inmates confined to ADTC are assigned to both a primary therapist and a primary therapy group.

The composition of each primary therapy group is not determined by the sexual orientation of inmates. Initially, the therapy groups were comprised of inmates who had committed the same sex offenses. However, this arrangement proved ineffective because the inmates tended to support one another's point of view during the therapy sessions, thereby undermining any attempt at rehabilitation. In order to avoid this problem, the primary therapy groups now consist of inmates who have committed various sex offenses, thus providing different perspectives on any given inmate's experience. The therapy sessions are conducted in a group format because the overwhelming majority of sex offenders at ADTC have difficulty in their relationships with their peers, a difficulty which is often at the root of their sexual problems. Intensive group therapy has proven to be the best method of addressing these problems.

Each therapist utilizes the style, methods and techniques which he/she believes to be most effective. This runs the gamut from behavioral, cognitive, relational/gestalt to the more psychodynamically oriented approaches. The treatment staff recognizes that traumatic childhood experiences, including sexual abuse, may be significant factors in the developmental history of many offenders. These experiences are often highly defended or repressed.

There are 16 full-time clinical psychologists who operate groups at the institution. At present, approximately sixty primary therapy groups are in operation at ADTC. Twelve to twenty offenders are assigned to each group. All the groups meet on a weekly basis. Therapy groups meet for 1½ - 2 hours each week for fifty weeks, thus the offender has access to 90 hours of extensive group therapy per year.

The format of each group varies, depending upon the background of the primary therapist who runs the group. In most groups, each therapy session focuses upon a particular inmate who takes the floor to discuss his problem. Occasionally, the emphasis may be on group discussion without focussing on any specific inmate. There are a variety of ways an inmate may take the floor: by request in advance through his therapist; by asking during group; or by

a preset schedule made by the therapist. If an inmate has a problem which he feels is emergent and requires immediate attention, he may be permitted to speak in place of a scheduled inmate. In addition, members of the group who are not assigned to speak at a particular session are, at all times, encouraged to speak out with respect to their own sexual problems. Participation by all group members is freely encouraged because the members often learn from their fellow inmates and may find that certain issues raised in the discussion sessions are relevant to their own experiences.

INDIVIDUAL THERAPY

In addition to group therapy, the primary therapist also offers, time permitting, individual psychotherapy to group members in order to supplement the work done within the group. In some cases, where appropriate or necessary, regularly scheduled sessions might be set up; in others, inmates may be seen on a more informal basis, or for emergency sessions in between regular meetings where a crisis arises.

Specific techniques can range from indepth interviewing of past history and feelings, mirroring, role playing, covert sensitization, supportive and negative reinforcement, biofeedback, direct confrontation, use of tape and book libraries, and many others.

ANCILLARY GROUPS

Inmates who feel that they need additional help may request placement in one of several ancillary programs available at ADTC. The determination as to whether an inmate may participate in any of these ancillary programs is within the discretion of the primary therapist assigned to the inmate. The ancillary programs available to inmates at ADTC are as follows:

Marital/Couples Therapy:

Marital/Couples Therapy, conducted in either a group setting or individually, is held with the purpose of fostering growth and development of each man, and his "significant other," through an exploration of their relationship. Specific goals include: (1) to teach effective communication skills; (2) to establish a working alliance with one's partner in order to deal with issues of mutual concern; (3) to increase understanding and awareness of self and others; and (4) to foster the growth and development of the couple's unit. Issues may vary from sexual preferences and dislikes to questions of effective parenting. The co-therapists adhere to no specific format but may vary from the teaching of assertive skills to modeling arguments. One positive by-product of this group is the cohesion established between many of the women, which continues outside the group.

Family Therapy:

Since, real or imagined, the family unit is often perceived by the inmate as instrumental in the development of his pathology, to not treat this important factor in his life and to have the man return to the same environment from which he came invites the chance of similar dynamics recurring. Clearly family members have to be willing to share their perceptions and feelings with one another, and through this gain a sense of cohesion, understanding, and tolerance. They can work on resolving past conflictual issues while planning how to re-establish their contact when the man is released. Family therapy is the suggested modality for these problems and is offered by the primary therapist, as needed, by appointment.

Sex Education Therapy:

The presence of sexual misconceptions regarding sexual roles, behavior and identity have clearly been indicated as contributing factors in offender's sexual crimes.

Therefore, sex education is offered to inmates who are sexually naive, lacking in knowledge or techniques and experience, and who could benefit from work on issues of sexual identity and misinformation. This is in addition to regular therapy. Three successive levels are offered on a one semester basis: Basic, Advanced and Sex Therapy. Each ends with a final examination and awarding of a certificate of completion. Visual presentations in film, slides, tapes, etc., are utilized.

Victim Empathy:

Understanding and fully appreciating the pain of sexual assault victims is an important factor in rehabilitating sex offenders. The Victim Empathy group attempts to enhance this understanding by helping offenders work through the psychological dynamics of their own victimization while appreciating the experience of other victims.

Social Skills Training:

Deficiencies in social skills, i.e., assertive skills, planning abilities, heterosocial and psychosocial skills, problem solving skills, abilities to deal with stress and feelings, and the general conflicts in their everyday lives, are common variables in the personalities of many sexual offenders. The goal in the S.S.T. group is to effect remediations in these social skills areas through a process of skill training using a structured learning approach.

In pursuit of these objectives, learning procedures such as modeling, role playing, performance feedback and behavioral rehearsal are used.

Anger Management:

For most sex offenders, there is difficulty in the appropriate and well-modulated expression of anger. Usually, they are either too volatile and easily overwhelmed by hostile impulses or too passive and unable to express any negative emotion.

The Anger Management Group focuses upon the difficulties by analyzing each individual's anger in terms of which external events are likely to trigger anger, which internal factors (expectation, self-statements, personalization) contribute to any, and which behavioral responses are likely to occur. Part of the process involves the differentiation of effective and appropriate anger responses from self-defeating ones.

Mainly cognitive and behavioral techniques are utilized in this group, including internal meditation, role play, and relaxation training.

Sexual Addiction Group:

Modeled on the concept of Sexaholic's Anonymous, this group allows the sex offender to deal with the process of sexual addiction. Focus is placed on understanding the rituals of addiction so that the offender can move into the recovery phase of addiction.

Relapse Prevention:

Many compulsive sexual offenders, even with treatment, pose a high risk of reoffending when placed back into the community. The relapse prevention group is designed to teach the offenders to recognize the warning signs of what might trigger their relapse, and then teaches specific skills to cope with their emotions to prevent relapse. Role playing is extensively utilized to test the skills learned.

PARA-PROFESSIONALS:

There are nine para-professional groups led by inmates who have displayed particular ability to assist others as a "peer group" leader. It is felt that inmates would be able to relate to other inmates and help one another in their therapy issues much as in the self-help theory of drug rehabilitation programs. This program is intended to supplement the primary therapy of the inmate. Since para-professional therapy aides are in the ADTC twenty-four hours per day, they then become valuable resources to counsel and handle emergencies when the professional staff is absent.

Each of the groups has a general theme on which, to differing degrees, they concentrate. For example, one is for drug problems, another is specifically for returning parole violators, another is relaxation training, and there is one for Vietnam veterans, etc. All sessions are monitored by a professional staff member and videotaped for both playback and training use. The para-professional therapy aides are regularly supervised, both individually and as a group, by members of the treatment staff.

AUDIO CASSETTE AND BOOK LIBRARY:

The goal of the audio cassette and book library is to provide therapeutically oriented educational materials for inmates. This allows them to continue their therapeutic learning on their own time outside of actual therapy sessions. The use of cassettes and books also saves therapeutic time, in that, inmates are educated through these media in various self-help skills.

VIDEO TAPES

In many of the above treatment program elements, extensive use is made of video-tape. While video-tape is often an ancillary treatment technique itself (playbacks, body language, etc.), it also serves a major role in the areas of supervision, training and education.

SOCIAL WORK COUNSELLING GROUPS

Pre-Release Group:

The goal of the Pre-Release Group is to help better prepare and assist those who are in the process of being released to come to terms with the realities of community life as opposed to institutional living.

Group and individual sessions are held covering a wide variety of topics such as vocational plans, job hunting plans, job interviews, dating expectations, finding an apartment, and so on. Meetings with ex-inmates in the Aftercare Program affords an exchange of information which focuses on the realities of life in society after being institutionalized as a sex offender. This experience proves to be beneficial to both groups as they exchange information, advice and offer moral support to each other.

Orientation Counselling Program:

Most offenders admitted to the Adult Diagnostic and Treatment Center are experiencing their first incarceration and are therefore unfamiliar with institutional life.

The orientation program is a structured group that provides information on all aspects of the institution and its procedures. Speakers from the various departments provide information on the functions of their unit and discusses what is available to the incarcerated individual.

Counselling is provided to deal with the many fears and anxieties experienced by the newly incarcerated offenders and coping skills are taught to deal with the problems they are experiencing.

Substance Abuse Counselling:

The institution utilizes the services of Substance Abuse Counselors to provide specialized counseling groups for inmates with addictive disturbances involving drugs and alcohol. It is our experience that sexual offenders often utilize drugs and alcohol to reduce their inhibitions and allow themselves to act-out their deviant sexual fantasies. The provision of this service either through the referral of the primary therapist or admission screening addresses this problem and how it inter-relates with the sexual pathology.

AFTERCARE PROGRAM

Outpatient therapy is an extension of the overall therapeutic program at the ADTC. The major goals are to aid ex-inmates in making the transition from the institution to society. In general, outpatient therapy provides a measure of supervision and support.

Outpatient therapy is provided on a weekly or monthly basis, or as needed. Ex-inmates are typically expected to return either to the institution or to a mental health facility in their immediate residential area, usually on a weekly basis during the initial stages, then gradually reduced to bimonthly, monthly, quarterly and semi-annually, depending on therapeutic progress. Ex-inmates may attend an evening group or meet with their therapist on an individual therapy basis. Another option either as an adjunct or a primary basis, is the marital/ couple group.

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ADDITIONAL THERAPY OPPORTUNITIES

ANCILLARY GROUPS:	Conducted by a Therapist or Social Worker
Anger Management	Goal is to work on better handling aggression.
Couples Group	Goal is to provide better relationships with spouses.
Social Skills Training	Goal is to develop more self-assertiveness to become more comfortable in social situations.
Sex Addition 12 Step Program	Goal of program is to understand why sex act was repeated more than once inappropriately. 12-Step program follows similar guidelines as Alcoholic's Anonymous.
Substance Abuse AA/NA	Works on addictions to drugs and/or alcohol.
T.O.P.	Program designed to orient newly-arrived inmates to ADTC.
Sex Education	Designed to familiarize persons with the male and female anatomy. There is a beginner's course and an advanced course.
A.C.O.A.	Program is conducted similarly to the Alcoholic's Anonymous program.
Relapse Prevention	Designed to work on the prevention of reoccurrence of sex offense.
Victim Empathy	Viewing the offense from the victim's perspective and intensively working through feelings of victimization.
PARA-PROFESSIONAL GROUPS:	
A.C.E.	ACCEPTINGD THE CONTRA-SEXUAL ELEMENT OF OUR PSYCHES. Goal is to examine our fears about feminine qualities within, such as vulnerability, sensitivity and nurturing behavior, or our feelings, moods and emotions.
A.D.U.	ABUSING THOSE WHO DEPEND UPON US. Victims were under our authority and abuse took place within the family system.
B.A.R.	BETTER AWARENESS OF OUR RAPE BEHAVIOR. For those who have committed the crime of rape or display rape dynamics in their behavior.
F.R.E.E.	FREEING REPRESSED EMOTIONS AND HEALTHY EMOTIONAL EXPRESSIONS.
G.O.O.D.	GETTING OVER DIVORCE. Working through failed relationships.
H.O.P.E.	HELPING WITH OVERWEIGHT PROBLEMS AND EMOTIONS.
MEDITATION	Goal is to provide suggestions to aid in relaxing that can last a lifetime.
O.L.E.	OUR LATIN EXPRESSION. Dealing with problems related to crime and culture.
RELAXATION	Attempts to work on dealing with stress constructively.
S.A.F.E.	UNDERSTANDING MY SEXUAL ACTIONS AND FANTASIES EXPRESSED WITH CHILDREN. Open to individuals who have committed crimes against children who were not related to the offender.
U.S.E.	UNDERSTANDING OUR SEXUAL EXPRESSION. Goal is to gain insight into why there is such a strong compulsion to express ourselves sexually.
V.E.P.P	VICTIM EMPATHY PARA-PRO GROUP. A continuation of victim empathy ancillary group. Focuses on reinforcement of empathy skills.
V.I.V.A.	Group open to any former serviceman, whether in active service or in the National Guard.
W.T.O.R.	WORKING THROUGH OUR RAGE. A continuation of anger management group.

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EDUCATIONAL OPPORTUNITIES AT THE ADTC

A. Academic Programs

Academic programs are offered for inmates with various levels of ability. Students are assigned to the programs on a half-day basis by the institution's Classification Committee. Assignment to a particular program is based on the student's reading level. School work is individualized to the abilities and academic needs of the particular student.

1. The Adult Basic Education (ABE) program provides basic instruction in reading, mathematics, and grammar.

2. Adult Education (AE) provides instruction to students who have mastered these basic skills.

3. The GED program provides instruction in English, reading skills, writing skills, and mathematics to students who are working toward a high school diploma. The GED test is offered here twice a year. Students who pass the test earn high school diplomas.

4. English as a Second Language (ESL) provides instruction to students whose primary language is not English.

5. College course offerings will be announced when available by the Education Department.

6. Night School is a part-time program which provides interested students the opportunity for supplemental instruction in weak areas.

B. Art and Hobby Programs

1. The Art Program provides introductory and advanced courses in Ceramics and Fine Arts.

2. The Hobby Program provides each inmate the opportunity to order approved materials and to participate in selected hobby activities during his incarceration.

C. Other Programs

1. Computers and Data Processing provides instruction in computer literacy and programming skills. Advanced computer courses are available to those who successfully complete the course.

2. The Podium is the inmate newspaper. Each month, the Podium publishes original articles, poems, and artwork.

3. The General Library provides access to books, magazines, newspapers, and reference materials.

4. The Law Library provides legal access services to the inmate population.

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ADULT DIAGNOSTIC AND TREATMENT CENTER

APPROPRIATIONS/CASE RATIO/RELEASE STATISTICS

FISCAL YEAR	APPROPRIATIONS MILLIONS	NUMBER OF THERAPISTS	RATIO OF THERAPISTS TO INMATES	INMATE POPULATION END OF FY	INMATES PAROLED	INMATES RELEASED TO X-MAX
'80 - '81	3.536	10	1 to 21	209	24	7
'81 - '82	3.874	10	1 to 23	233	18	14
'82 - '83	3.882	10	1 to 25	261	15	7
'83 - '84	4.668	11	1 to 27	297	17	9
'84 - '85	4.798	12	1 to 25	314	14	12
'85 - '86	5.436	16	1 to 23	362	6	18
'86 - '87	6.147	16	1 to 25	402	13	34
'87 - '88	10.157	15	1 to 31	466	15	45
'88 - '89	11.330	17	1 to 27	466	13	55
'89 - '90	16.204	16	1 to 39	619	8	79
'90 - '91	17.077	18	1 to 37	666	5	88
'91 - '92	17.741	15	1 to 45	681	11	140
'92 - '93	18.478	16	1 to 43	685	11	96
'93 - '94	19.422	15	1 to 47	703	12	108

UPDATED: 8/1/94

SEX OFFENDER OUTPATIENT EVALUATIONS

FISCAL YEAR	EVALUATIONS COMPLETED	PERCENT UNDER ACT	NUMBER UNDER ACT
FY '76	375	24.0	90
FY '77	509	16.0	81
FY '78	483	15.0	72
FY '79	506	17.5	89
FY '80	423	16.0	68
FY '81	415	21.0	87
FY '82	451	24.0	108
FY '8	464	13.5	63
FY '84	439	27.0	119
FY '85	594	29.0	172
FY '86	658	30.0	195
FY '87	510	28.0	147
FY '88	631	34.7	219
FY '89	566	34.4	195
FY '90	523	33.3	168
FY '91	573	29.0	160
FY '92	541	30.0	158
FY '93	516	30.0	154
FY '94	757	34.0	203

The Recidivism of Sex Offenders
Is Treatment Programming Cost Effective?

by
Nancy Steele, Ph.D.

INTRODUCTION

For many years administrators and legislators worried about budget constraints, public opinion, overcrowded prisons, and the expectations of greater public safety have asked the questions about effectiveness, cost and possible benefit of sex offender treatment. The staff involved daily in sex offender programs across the country have struggled to come up with answers while also trying to provide quality treatment. While funding has been minimal for most programs across the country it has been even more lacking for research on these programs so a lot of research has been done out of borrowed time. Admittedly, when research is done by staff on their own programs there is a potential for a bias that puts treatment in a better light but that is why replication of findings is important. Gradually data from different places and across different periods of time is beginning to show a picture on the benefit that can be expected, or has been achieved thus far with sex offender programs.

One of the first objections always raised about recidivism studies is that we don't know the "true " recidivism of sex offenders. Many if not most crimes are unreported and undetected. This seems to be true based on what we know from victim studies and even from offender studies. Groth and Logo report (1982) on a study they did with 83 rapists and 54 child abusers incarcerated in two different states. They asked the offenders to fill out a questionnaire anonymously saying how many crimes they had actually committed. This was compared to the number of convictions recorded in the offenders combined Pre-Sentence Investigation reports. They report an average of 14 undetected assaults for each rapists and eleven undetected involvements for each child molester. This represents separate children being unknown victims of sexual assault not simply undetected repeated events with the same known victim. Data reported by Abel, et. al (1987) indicates similar high rates of undetected crimes when offenders are given a seal of confidentiality from the federal government.

Most therapists working in the field will tell you that when an offender gets serious about treatment he'll often tell you a lot about crimes he was never caught for. Clinical experience and academic studies converge on the point that there are more offenses than we know about officially. This does not mean we should not use the official data we do have, nor does it mean we should abandon research altogether. We have to temper our obtained results with the knowledge that these are undoubtedly underestimates.

Another problem with many recidivism studies is they have tended to simply ask the question does treatment of sex offenders work? Researchers have tried to answer this question by looking at one group of treated offenders in one setting and then hoped to generalize to all sex offenders

in all settings in all types of programs. This kind of confusion in the field has caused some researchers to conclude that " their is no evidence that anything works". Lita Furby and associates (1989) unfortunately came to this conclusion and published it in her Psychology Bulletin article. Readers Digest, unfortunately, then popularized this notion in an article of their own based on her survey of research articles. Her original review looked at 42 studies from different settings using different kinds of sex offenders across huge periods of time. Some of her studies were carried out in Great Britain and Europe and involved behavior that would not be considered "criminal" today. We need to better define our questions and ask what kind of treatment works for what kind of sex offenders in which settings. The rest of this chapter will compare studies of programs and recidivism from different settings. The last section will deal with the cost of treatment compared to the cost in dollars of a new sex offense.

PRISON PROGRAMS AND RECIDIVISM

The number of sex offenders in prison has risen dramatically in the last few years. If we look at the number of sex offenders in prison in the United States, they have increased by 48% from 1988 to 1990. (Corrections Compendium, July 1991) During this same time period the total prison population in the United States increased 20% Overall 12.3% of the people in prison in the United States in 1990 were there for a sex offense. This does not include the likely increase in numbers of sex offenders who were convicted and sentenced to probation in the community. Presumably huge numbers of these offenders were left in the community with treatment programming, county jail time and community supervision a condition of their probation.

Does this reflect an increase in the number of sex offenses committed? Probably not but it does reflect an increased awareness of, attention to, and concern about sexual crimes. Prosecutors and elected officials are getting the message from the public that they want these crimes treated more seriously and offenders held more accountable .

What is the expected recidivism of sex offenders without treatment? This is the major problem in judging most treatment studies. Most studies lack a matched comparison group of untreated sex offenders. Without a base rate for comparison one is often left guessing as to how effective a reported treatment outcome is. Fortunately in 1989 the National Institute of Justice published a study (Beck, 1989) on the recidivism rates of 108,580 inmates released from state prisons in eleven states, including New York, Ohio, New Jersey, Texas, California, Florida and five others, states. This represented over 1/2 of all prisoner in the United States released from state prisons in 1983. He looked at about 16 different types of crimes that offenders had been serving time for and then reported on rearrest and reconviction rates for these offenders 3 years after release from prison. The rates for sex offenders are presented in Table I.

Table I
Recidivism of Sex Offenders

Type of crime	% rearrested	% reconvicted
Rape	51.5	36.4
Other Sex assault	47.9	32.6
All offenses, combined	62.5	46.8

While these percents are not a controlled comparison group for treated offenders released from prison they do give us a base to judge some treatment studies by. The rearrests and reconviction were for any type of felony not necessarily a new sex offense. Are released prisoners rearrested for the same type of crime they went to prison for in the first place? In general prisoners were not rearrested for the same type of crime they went to prison for. Two groups had a much higher likelihood of repeating in kind. Beck (1989) reports that those released for rapes and other sexual assault, are 10.5 and 7.5 times more likely to repeat the same crime than is any other group of offenders. This is the rational which might justify a specialized treatment program in a prison for sex offenders.

When do the new crimes occur? Beck (1989) found what many other criminologists have found that in general men released from prison are most likely to be rearrested in the first year after release. Although he followed the offenders for three years two thirds of those rearrested were arrested in the first year after release. The rate of rearrest begins to drop off significantly after that. This is important because; it is frequently asked how long should we follow a sample of subjects? Although the recidivism always goes up slightly the longer a group is followed the payoff is undoubtedly the biggest in the first few years. What one gains by following them for 10 or 20 years is not clear given the additional difficulty involved. One may be able at gather a lot if not most of your information on the effects of a treatment program by following the participants for just a few years after release. Another question that has to be asked in doing research is at what point are you measuring the effects of the institution treatment program and when do you begin to see the effects of what happens to the man in the community? Ten to twenty years after a man is released from prison so many things could have happened or not happened to him in the community it hardly seems reasonable to assume that a treatment program effect would last forever, even if we might wish it to. Usually with cancer studies for instance patients are followed for five years and considered "cured" if the disease does not reoccur in that time.

Results are summarized here from five different states with institutionally based programs. Some of these programs were carried out in state hospital settings but they largely drew their sex offenders from the prison population. These programs were around long enough to generate sizable number of offenders and follow up data. They are likely to be similar in their approach and working with the most aggressive sex offenders. Studies are presented in Chart II from Wisconsin, Washington, New Jersey and Minnesota.

Chart II
Recidivism Rates from
Four Institutionally Based Programs for Sex Offenders

	Years of follow up	% of new Sex offense	% of other felonies	Total %
Wisc. N = 475 1962	1-11	15.6	2.4	18
Avenel NJ N = 324 1978	0-10	9.3	11.7	21
MN: TSOP N = 428 1991	1-11	10	completers	16
		12	Non-completers	22
WA: Ft. Stelicome N = 402 1979	0-12	22.1		

Source: "Sex Offender Recidivism: A Review" Furby et. al 1989
Minnesota TSOP Data analyzed by Steele, 1993.

Wisconsin ran a treatment program in their prison from 1950 through the 1970's treating rapists and other aggressive sex offenders. They report on 475 men released from their program with a 1-10 year follow-up. Eighteen percent had their parole violated or were convicted for a new felony. This compares favorably with the approximate 34 % of sex offenders who were reconvicted of a new felony within three years of release from prison as reported in the NIJ study. The numbers may be lower because in the early 1960's when this study was done we did not have as many convictions for sex offenses, or it maybe that this program actually worked quite well.

In New Jersey which has an entire prison for treatment of sex offenders 324 men released after" emotional release" therapy show a reconviction rate of 21 % for new felonies with a 0-10 year follow up period of time. This would seems to be an improvement over the 34% reconviction rate reported by Beck (1989) for the prison group without treatment.

Although three of these programs also report the percent of offenders reconvicted of new sex offenses as separate from those convicted of other felonies, this writer has found that to be an almost meaningless comparison. The criminal justice system with its system of plea bargaining and eagerness to avoid trials is usual willing, at least in current times,

to accept a plea bargain for assault, kidnapping, burglary or even robbery for a criminal action that for some sex offenders , is clearly part of their sexual assault cycle. Given the load of work placed on our courts the prosecutors offices decisions about how to charge and convict in a criminal action are generally based on what it is easiest to prove in court, or what the offender is willing to plead guilty to. In addition someone is often concerned with trying to protect the victim from having to testify in court so that very often guilty pleas to other types of charges are accepted and the criminal justice record does not reflect a new sex offense even when the pattern is obvious to anyone who knows the offender and his typical cycle of offending. Kidnaping for instance maybe the criminal charge for some behavior, that is in realty an actual rape or attempted rape. A great deal of important and valuable data will be lost if new convictions for sex offenses only are considered as a measure of recidivism.

The state of Washington operated their Ft. Stelicome program in a state hospital but their clients were convicted of criminal charges and would have been in the state prison in most cases if they weren't placed in the treatment program. Unfortunately their studies report recidivism only in the form of new sexual felonies. They are included in the chart for comparison with the other larger institutionally based programs. Their recidivism on sexual crimes is similar to the other institutional programs.

In Minnesota, the Transitional Sex Offender Program, TSOP, started in 1978 in a medium security prison and ran for almost 15 years. This program reports data on 428 inmates 1-11 years after release. The data compares 303 men who completed the program on the top line with 125 men who failed to stay in the program after their first few months of treatment in the prison presented on the second line. The program was generally 10-12 months long in the prison phase of it and happened during the offenders last year of incarceration, it also included a four month aftercare phase in the community for some offenders. A sixteen percent recidivism rate for the offenders who completed the prison phase of the program looks similar to the other institutionally based programs over a similar period of time. The comparison group, of non-completers, with a 22% recidivism rate is still significantly better than the base rate of 34%. Since this program emphasized an intensive psycho-educational approach at the beginning of treatment it is possible that even the sex offenders who failed the program benefitted from going through the beginning stages of treatment although they did not do as well as those who finished the program.

The TSOP data collected on the return rates of program participants has been analyzed (Steele, 1993) as to types of sex offenders who completed the program and those who did not. In this case the reoffense data is presented only for new felonies that occurred within three years after release from prison. The percents for the entire 11 years are similar but the differences between completers and non-completers are smaller. The shorter follow up period is in some ways a better measure of treatment impact since one would expect any treatment effect to decrease as years in the community went by with little or no community treatment. The program was a year long with a four month aftercare for some participants. This also allows the comparison of these recidivism data directly with the NIJ study. This is presented in Table III.

Table III
PERCENT OF SEX OFFENDERS COMMITTING NEW FELONIES
WITHIN THREE YEARS OF RELEASE FROM PRISON AFTER PARTICIPATING IN
THE TSOP PROGRAM

RAPISTS	N = 204	48%	OF THE SEX OFFENDERS
Completers	N = 138	14.49%	new felonies
Incompleters	N = 66	27.27%	new felonies
INCEST OFFENDERS	N = 160	37%	OF THE SEX OFFENDERS
Completers	N = 129	4.65%	new felonies
Incompleters	N = 31	6.45%	new felonies
CHILD ABUSE OFFENDERS	N = 58	14%	OF THE SEX OFFENDERS
Completers	N = 35	8.57%	new felonies
Incompleters	N = 23	20.83%	new felonies
OTHER SEX OFFENDERS	N = 6	1%	OF THE SEX OFFENDERS
Completers	N = 1	0%	new felonies
Incompleters	N = 5	20%	new felonies
TOTAL OF ALL TYPES	N = 428		
Completers	N = 303	9.57%	new felonies
Incompleters	N = 125	16%	new felonies

Return Rates collected by the MN Department of Corrections; Office of research and information 1991. Analysis of typologies by Steele 1993.

This is one of the first programs to report an improved effect in treating rapists. Most community based programs treat very few if any men convicted of rape. Although almost one third of the rapists failed the program those that completed it have a recidivism rate almost twice as favorable as those who did not complete, 14 % instead of 27% Offenders in general failed the TSOP program because they broke institutional rules, waived out or in a few cases were removed for not cooperating with treatment. Rapists did not have nearly as high a rate of failure in treatment as the extra-familial child abusers or the other sex offenders, which included exposers, voyeurs and an obscene phone caller. These offenders were usually in prison for a non-sex felony but were placed in TSOP because their record indicated they also had problems in the area of sexual assault. Given such a high rate of failure in the program, 40%, for the extra-familial child abusers it was surprising to see such a good effect for those who completed treatment. This group largely consisted of men who offended against male children, all of them outside of the family. The incest offenders were in general the best behaved men in the program so that they seldom if ever were removed from treatment. Their lower recidivism rate in general is consistent with several studies of

other programs which will be reported.

One final point about the Minnesota data worth mentioning is that Minnesota has the second lowest incarceration rate in the country for its population. This means that to go to prison in Minnesota the offender has usually committed a fairly serious sex offense. Four-fifths of the sex offenders convicted in Minnesota are managed in the community. The TSOP data includes a number of men convicted of murder and very serious mutilation of victims. Many of them responded well to treatment and have maintained success in the community years after release. This contradicts an idea often mentioned in the literature that "sadistic" rapists cannot be treated. It is true that for political reasons it may be risky to try and treat the most violent offenders especially in the community, but experience with this program would seem to indicate that some rapists or very aggressive offenders can and do respond well to a treatment approach in a prison setting.

The last state to be reported on for institutional programs is California, The first Atascadaro State Hospital treatment program ran for over 30 years. Four major studies have reported on over 2,000 sex offenders released from this program. One of the better studies published by Sturgeon & Taylor (1980) reports on 260 treated offenders, 1-5 years after discharge and compares them to a matched control group from the prison of 122 untreated sex offenders. They report their results in terms of a subsequent conviction for a new sex offense. Results are reported in Table IV.

Table IV
Atascadaro State Hospital
Percent with a New Sex Offense Conviction
Released 1973

Sturgeon & Taylor (1980)	Treated Hosp. N =260	Untreated Prison N = 122
Heterosexual Ped.	19.8%	17.9%
Homosexual Ped.	14.6%	37.5%
Rapists	19.3%	27.9%
Incest	5.3%	0
Total	15.4%	25%

The 25% versus 15% in reconviction rates is a sizable difference. Here we also have a control group of similar inmates in prison who had a significantly higher recidivism rate with no treatment. It is important to look at the effect of, type of sex offender studied on reconviction rates. Most of the treatment payoff in these studies came from treating the male child abuser. Similar to the finding in the TSOP study. This group is known to have the highest of recidivism rates and thought to be very hard to treat, but apparently this hospital program had pretty good success with the ones that finished treatment.

COMMUNITY BASED PROGRAMS

For years outpatient programs in the communities in the United States and Canada have treated less violent sex offenders as a condition of probation. This has included exhibitionists, voyeurs, non violent pedophiles, incest offenders and less serious rapists. Most outpatient programs have been reluctant to treat the aggressive rapists, fearing repercussions on their program if a reoffense brings a lot of publicity. In addition most courts in recent times have chosen to send the more violent rapists to prison rather than risk the same public criticism. A very different category of sex offender is usually treated in the community.

While it is true that these type of offenders commit less violent acts they do tend to have a recidivism rate that is much higher than those who are more typically sent to prison. An early study (Frisibie & Dondis, 1965) on the first Atascadaro Hospital program reports that treated voyeurs were recidivating at 46% and exhibitionists at 41% with a 1 to 5 year follow up. For this reason Maletzky's (1987) study on 2,781 offenders in Oregon with a 14 year follow up looks impressive. Results are summarized in Table V.

Table V
A Community Based Outpatient Treatment Program

MALETZKY (1987)	1-14 YEARS follow up	% WITH NEW SEXUAL CRIMES
1719	female child molesters	12.7
513	male child molesters	13.6
462	exhibitionist	6.9
87	less violent rapists	26.5

Clearly the treatment approach being used by this clinic was having a very good effect on sex offenders who generally have a high rate of recidivism. His rate of 6.9% recidivism is quite a bit better than the 41% recidivism for exhibitionists reported in the Atascadaro study. One factor in their success maybe that this program as most outpatient programs in the United States, tends to treat sex offenders in the community who are able to pay for their treatment and so these men may in general have more resources and support than those who are sent to institutions.

Similar effective results have been reported from The Kingston Sexual Clinic in Canada that treats offenders on an outpatient basis. They have presented data in a study (Marshall & Barbaree,1988) with a matched control group of untreated offenders. Men in both the treated and untreated groups admitted their crimes and asked to be involved in treatment. Their results are summarized in Table VI.

Table VI
Kingston Clinic Outpatient Program
for Sex Offenders

KINGSTON SEXUAL CLINIC AVERAGE 4 YEAR FOLLOW UP	TREATED N = 126 % NEW SEX CRIMES	UNTREATED N = 58 % NEW SEX CRIMES
female child molesters	7.5	17.9
male child molesters	5.5	19.2
incest	2.9	7

In this study also the treated offenders have a lower recidivism rate, especially the male child molesters seem to benefit from treatment, 5% compared to 19%. In this study also the incest offenders have the lowest rate of recidivism. The lower rate for the incest offenders may in part be a reflection of the shorter average four year follow up period.
Abel et al. (1988) have reported a recidivism rate of 12.2% after a one year follow up period. They are treating extra familial child abusers who have abused boys, girls and some who have abused children of both genders. The higher recidivism rate that Abel finds with treated extra familial child abusers probably comes because his offenders were guaranteed immunity by the federal government and self reported, probably at a higher rate than sex offenders in other studies who had no such immunity.

In general there are a number of studies which suggest that outpatient treatment in the community of some sex offenders is effective. The cost of treating men on an outpatient basis in the community where they often pay for their own treatment is far less. If offenders are able to maintain their employment, keep their families off welfare and the state does not have to pay for their incarceration the savings for the tax payer will be considerable. The problem of course is balancing the economics involved with the risk level for the public. In several states where outpatient programs are available incest offenders are considered the safest offenders to manage in the community. They often do not have a history of abusing children outside their own family and so the public at large is not at risk and children of the offender can be protected by restricting contact with them. If incest offenders demonstrate a willingness to avoid contact with their own children they present the least risk for treatment in the community compared to other types of sex offenders.

COMBINED INSTITUTION AND COMMUNITY PROGRAMS

The most recent programs begun in the last few years have been able to combine inpatient and outpatient services to their clients. Particularly worth noting is the current treatment program at the Atascadaro State Hospital in California. The legislature in that state had the wisdom and foresight in 1981 to eliminate their commitment statute to the state hospital and to order that all sex offenders be sent to the state prison system. They also created at the same time a new experimental program that was to be "established according to a valid experimental design" that would allow the state to rigorously test methods of treating sex offenders. This smaller 50 bed program was started in 1985 with sex offenders who

volunteered to come there from the prison system two years before their release from prison. Since this is funded as primarily a research program the design from the beginning has included two control groups matched for age, type of crime, and severity of criminal history. One control group consists of men who volunteered for treatment but were randomly selected to not participate. The other control group also matched on the same variables consists of sex offenders who did not volunteer to participate in treatment. The program includes two years of institutional treatment following a relapse prevention model and a year of aftercare treatment in the community. They are seen twice a week in the community for a year by therapists trained in the relapse prevention model. Recidivism rates are actively being collected on all three groups and will be for ten years after their release. The recidivism percents are a combination of arrests and parole violations for sex offenses and other violent offenses. The most recent results(presented by Marquis, ATSA conference Boston, 1993) are shown in Table VII.

Table VII
Atascadaro California Research Program 1993

Type of group	Treatment N = 116	Vol.Control Gp. N = 126	Non Vol.Control N = 121
Time at risk	38 months	38 months	38 months
Rapists N = 78	23%	48%	28.5%
Child Molesters N = 285	7.8%	11.%	13.8%
Total N = 363	11.2%	19%	14.9%

This program further reports that a very low percent of their clients failed to complete the program, 15% dropped out and 6% were removed for disciplinary reasons. The most immediate point obvious from this data is that if the rapists volunteer for treatment it would be a good idea to believe them. Other reports from staff in the program is that much of the time prisoners willingness to volunteer had a lot to do with where their families lived in relation to the hospital or the prison they were currently in. It was also affected by the type of prison job or schooling they had their rate of pay and many considerations that would motivate any of us in deciding to leave a current prison and move to a hospital, possibly in another part of a very large state and enter into treatment. It seems possible from this data that researchers have historically overestimated the importance of the "volunteering factor" as an outcome variable in effect of treatment. Type of offender, age and severity of criminal history are probably the biggest factors which determine level of risk.
Overall these arrest rates approximately 3 years after release would seem

to compare favorably with the arrests rates in the Beck (1989) study. In that case rearrest rates were at 51 % for the rapists and 48% for other sex offenders. This would seem to indicate that the Atascadaro programming is treating sex offenders in the moderate range of risk. They exclude men with three felony convictions or more and that is probably the group that accounts for the higher level of arrests within three years of release from prison that is reported in the Beck study. This program should continue to yield valuable recidivism data of all sorts for the rest of this decade.

The other state with a continuous institution based program and a long follow up time in the community is Vermont which also operates on a relapse model. This is not a research designed program and it operates on a more modest scale. The institution program is a least a year long and the community phase is a year long. Pithers (1992) reports recidivism on new sex offenses with a 1-8 year follow up. He uses a very conservative estimate in that offenders were counted as recidivating if they were rearrested or believed by their parole officer or therapist to have committed a new sex offense. This criteria makes it difficult to compare results from this program with some of the others cited in this article. These results are presented in Table VIII

Table VIII
Vermont Relapse Program 1992
Prison + Community Involvement
One to Eight year follow up

Type of offender	Number of offenders	% New Sex Offenses
Pedophile	195	7
Incest Offenders	190	3
Rapists	53	19
Untreated SO in VT.	--	38

It is not possible to determine from his report what percent of the sex offenders fail the institutional program or in community phase and what their recidivism might be. It is consistent with other studies in that the incest offenders have such a low recidivism and the Vermont program would seem to be achieving success with the pedophiles based on reports from other programs. Overall the model of treatment in the institution followed by a similar form of treatment in the community for a significant amount of time a year or more would seem to be the direction the field is moving. It is particularly important that the rapists have some continuity in treatment since the few weeks after release are stressful for them and this seems to be a time high in risk for them. The effectiveness of continuity in treatment even for a few months after release is supported by data from TSOP in Minnesota.

Both the California program at Atascadaro and the program in Vermont offer a year or more of follow up in the community after the offender leaves confinement. Additionally the Atascadaro program is considered a model in the country for research design. The legislature mandated random assignment as part of the test of treatment effectiveness. Not only that they funded the program well with a lot of mental health staff. The

offenders are recruited from the prison system. Results from these two programs have a shorter follow up period because they have not been around as long.

COST ANALYSIS

It should be obvious that the current state of the art is such that treatment does not eliminate all sex crimes at best we can say that there are indications that it cuts the recidivism rate slightly somewhere between 10 and 30% roughly. Does this make up for the cost of treatment? Is it worthwhile to go on trying to find better methods and improve what we do? Doesn't treatment and research cost a lot of money?

Prentky and Burgess (1990) sought to answer that question by looking at the cost of treatment in the Massachusetts program which has operated for years in the state hospital in Bridgewater Massachusettes. They compared 129 child molesters treated in that program and released, with a control group of untreated child molesters from Canada. In both cases they looked at charges on new Sex Offenses in a 5 year follow up. They found that 25% of the treated child molesters were charged with a new sex offense which compared favorably with 40 % of the untreated abusers being charged with a new sex offense.

They also computed the cost for a new detected sexual crime against a child, one victim. Those costs included investigation, arrest, prosecution, incarceration for an average of seven years and no treatment for the offender for an expense of $169,029. Expenses for the victim which included treatment and care came to $14,304. This assumes one victim, we can be sure that for everyone they are caught on there are probably some others that aren't detected. This assumes the person goes to prison for 7 years on what might be a second or third conviction. Obviously is some states he might go to prison a lot longer than that.
He then compares this with the cost of treating the offender in the Bridgewater program. In their state those who were released from treatment were in confinement for an average of 5 years instead of the seven years in prison. It turned out that the cost of treating one offender for five years in the hospital based program was $118,146. considerably less than the cost of one new sexual offense which came to a total of $183,333, combining both the offender expenses and the victim offenses.

This number for one new sex offense may seem exceedingly high but it is not too different from the costs that Pithers(1987) found in a Vermont study. The cost of one new offense was about $152,000. He also was figuring the costs for arresting, investigating, prosecuting and confining the offender and supervising him on parole as well as the cost of services to the victim.

The cost factors associated with the Transitional Sex Offender Program in Minnesota were figured in a different manner. Since this program is about 10 months long and all of the offenders were in prison anyway the program looked at the additional cost of treatment over the cost of incarceration in the same prison without treatment. TSOP was largely run by using existing correctional staff that were assigned to the living unit including correctional officers, plus three additional treatment staff. The cost is shown in Table IX.

Table IX
Transitional Sex Offender Program
Costs Averaged over two years
July 1989 - July 1991

Treatment Costs: 41 bed unit

Salary 3 additional positions	$111,945.
Travel Expenses	1,211.
Supplies	1,093.
Deaf interpreter	2,683
Total Expenses	$115,591.

Prison cost per day per inmate	$67.21
Treatment cost per inmate per day	7.73

Treatment of one offender = $7.73 X 320 days = $2,473.60.

Cost of a new Sex Offense = $183, 333.

As can be seen from the above chart the cost of incarceration per inmate per day in Minnesota is higher than it is in some other states, but it is certainly not as high as the cost of hospitalization in most states and these expenses would have existed with or without a treatment program. The point being that we have spent a lot of money to prosecute and incarcerate offenders in almost every state the additional cost of some treatment while incarcerated is small by comparison. If we use the cost from the Prentke study for a new offense it appears that TSOP could afford to treat 74 sex offenders if it could assist in preventing one new sex offense among those men participating in the program. Treatment is more expensive than simple incarceration but it is not a lot more expensive and it has promise of improving public safety.

Most important of all programs need to be researched as efficiently as possible to better decide which elements pay off or are the most important in which settings. What might be critical for an incest offender in the community, like family therapy may be relatively unimportant in a prison setting with rapists. Perhaps rapists can only begin their treatment in the confines and control of a prison setting but they and the community would benefit from a longer followup time of treatment in the community after release. Unless legislators and the public in general start paying careful attention to costs and benefits of all interventions, prison, probation treatment, education, vocational programs it will continue to be difficult to make decision about how to best allocate public funds. The fundamental question remains. Which of all the things we do in this difficult and emotionally charged area really increases public safety. What is money well spent and what is simply the appearance of "getting tough"?

This chapter is not meant to be a comprehensive review of all the articles on program effectiveness. It is a look at some programs in some settings that show promise of being effective. This chapter seeks to show the differences in types of sex offenders being handled in different

settings and the importance of separating these issues when trying to judge programs and make decisions. Different as many of these studies are across times and locations there is a similarity in their findings that is compelling and adds validity to each study. It should also be obvious that there is a great need to better standardize terms in this field so that findings in one location can be better compared with findings in another. Knowledge in this new and developing field as in many others is built on experiences of others methodically and systematically reported.

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