MEETING

of

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

"Testimony regarding the reorganization of the ADTC therapy program"

LOCATION: Woodbridge Public Library
George Frederick Plaza
Woodbridge, New Jersey

DATE: February 1, 1995
10:00 a.m.

MEMBERS OF TASK FORCE PRESENT:

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

GENERAL ASSEMBLY:
Assemblyman Stephen A. Mikulak, Chairman
Assemblywoman Marion Crecco
Assemblyman Joseph R. Malone, III
Assemblywoman Barbara W. Wright
Assemblywoman Shirley K. Turner
Assemblyman Charles "Ken" Zisa

Gregg Muller
William H. Thomas
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

Meeting 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
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M E E T I N G N O T I C E

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 - February 1, 1995**

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 **Wednesday, February 1, 1995 at 10:00 AM at the Woodbridge Public Library, George Frederick Plaza, Woodbridge, New Jersey.**

The task force will receive testimony from at least 10 witnesses, including William Plantier, the Superintendent of the Adult Diagnostic and Treatment Center (ADTC); Wayne Sager, Director of Psychology at the ADTC; and Dr. Nancy Griffine concerning the reorganization of the ADTC therapy program. Six persons who provide treatment to sex offenders also will testify. The task force also will receive testimony from Dr. Louise Riscala, Ph.d, former Director of Psychology at the New Jersey Diagnostic Center at Menlo Park, where sex offenders were treated prior to the establishment of the ADTC.

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SENATOR C. LOUIS BASSANO (Senate Chairman): Will everyone please take their seat so we can get started?

I'm going to ask staff to do a roll call of Task Force members.

Anne, you want to do that, please?

MS. STEFANE (Task Force Aide): Senator Bassano?

SENATOR BASSANO: Here.

MS. STEFANE: Senator Kosco? Senator Inverso? (no response) Senator Matheussen?

SENATOR MATHEUSSEN: Here.

MS. STEFANE: Senator Girgenti? (no response) Senator McGreevey?

SENATOR McGREEVEY: Here.

MS. STEFANE: Senator O'Connor? (no response) Assemblyman Mikulak?

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

MS. STEFANE: Assemblywoman Crecco?

ASSEMBLYWOMAN CRECCO: Here.

MS. STEFANE: Assemblyman Malone?

ASSEMBLYMAN MALONE: Here.

MS. STEFANE: Assemblyman Holzapfel? (no response) Assemblywoman Wright?

ASSEMBLYWOMAN WRIGHT: Here.

MS. STEFANE: Assemblywoman Turner (no response) Assemblyman Zisa?

ASSEMBLYMAN ZISA: Here.

MS. STEFANE: Professor Brooks?

DR. BROOKS: Here.

MS. STEFANE: Mr. Evans? (no response) Mr. Muller?

MR. MULLER: Here.

MS. STEFANE: Mr. Thomas?

MR. THOMAS: Here.

MS. STEFANE: We have a quorum.

SENATOR BASSANO: Thank you.

We're going to start taking testimony where we left off the last time. Before we get into some of the heavier testimony, I'm going to ask Carol Vasile--

Am I pronouncing it correctly?

C A R O L V A S I L E: Vasile. (indicating pronunciation)

SENATOR BASSANO: Vasile, from the Division on Women, who had requested the opportunity to make a very short statement.

Carol.

MS. VASILE: Good morning. I'd like to thank the Task Force for giving the Division on Women the opportunity to testify on such an important issue.

As Senator Bassano said, I'm Carol Vasile. I am the Supervisor of the Office on the Prevention Of Violence Against Women, for the Division on Women.

The people of New Jersey have been stunned by several highly publicized, shocking rapes and murders this past year, several having been committed by repeat sexual predators. Clearly, whatever we are doing for these criminals is not working.

Whether one subscribes to the theory that sexual predators are unable to ever be made whole because the window of learning behavioral change has been closed and locked, or that conventional therapy fails because it exists in the vacuum of a highly artificial environment where successful change cannot either be tested or measured, we are all in agreement that what this Task Force seeks to accomplish is of critical importance to the citizens we serve.

We are faced with the very real possibility that mental health professionals might never agree on what specific treatment will work so that sexual offenders might safely return to society.

The FBI has estimated that one in three women will be raped in their lifetime. The New Jersey Division on Women urges this Task Force to continue your assessment and deliberations of the Adult Diagnostic and Treatment Center, remembering that there were 2214 reported sexual assaults committed in this State in 1993, which is the last year for which the figures are available. That number represents what we believe to be only 5 percent to 10 percent of the acts of dominance, violence, and humiliation that actually occurred. Often, victims of sexual crimes never fully recover and they deserve our protection.

I have copies of this testimony that I will be passing out to the Task Force members.

SENATOR BASSANO: Thank you.

ASSEMBLYMAN MIKULAK: Thank you.

SENATOR BASSANO: Are there any comments on the testimony? Are there any questions? (no response)

Thank you.

Senator Inverso has just joined us.

SENATOR INVERSO: Thank you for that indication that I'm late. (laughter)

SENATOR McGREEVEY: He was just identifying new roads in Woodbridge Township for which he is dedicating funding. (laughter)

SENATOR BASSANO: We all got lost.

SENATOR INVERSO: As soon as I get it for South Brunswick, I will be glad to help Woodbridge. (laughter)

SENATOR BASSANO: Our next witness, Dr. Riscalla.

If you would be kind enough to join us? Perhaps you may be able to start by giving this group some background on yourself and what you have done over the years, before you get into actual testimony.

L O U I S E R I S C A L L A, Ph.D.: Oh golly, for 34 years? (laughter)

I'm a licensed psychologist. I have a background in neuropsychology. I'm a member of the National Academy of Neuropsychologists. I'm a Fellow at the American Academy of Behavioral Medicine. I'm a psychotherapist. I've been with the State service for 34 years. I retired two years ago from Greystone Park Psychiatric Hospital, where I was the principle clinical psychologist.

I originally had worked at the New Jersey State Diagnostic Center at Menlo Park before it closed. At that time, I had examined as a member of a team offenders referred by the courts throughout the State. When the Governor at the time closed the Diagnostic Center, I went to the Children's Diagnostic Unit at Avenel, and then up to Greystone where I completed my career.

I have over 100 publications in the field of corrections, mental health advocacy, diagnostic testing, etc. I have presented workshops at the American Psychological Association, the National Rehabilitation Association, and other professional organizations.

I'm currently on the Board of Directors of the Edison Chapter of AARP and I'm continuing my writing. Now that I have time, I'm concerned about giving back to the State what the State has given me over the years. I care about what I'm doing. I'm also a taxpayer and I'm very upset about our high taxes in this State.

SENATOR BASSANO: I'm correct that--

DR. RISCALLA: Now, as far as my testimony goes--

SENATOR BASSANO: I'm correct though, before you get into your testimony, that you worked with sex offenders at Menlo Park prior to Avenel?

DR. RISCALLA: Yes, for years. I've worked with juveniles as well as adults.

SENATOR BASSANO: I just want to get that out so that people understand what you did.

DR. RISCALLA: I have seen many of them over the years and attempted to treat some.

I'm going to break up my testimony into several sections, dealing with administration, treatment, and research.

Under the current system there are many disciplines doing therapy such as social work, psychology, psychiatry, education, corrections, etc., with the consequence of a risk of inconsistency in the type of treatment given.

In addition to that, you have the Civil Service Regulations which confound the issue that the staff are appointed from a Civil Service list. If you cannot justify why you don't take a particular staff member, then you're liable to penalty under Civil Service Regulations. You also have unions represented which confound the issue further. So, actually, there is no way of controlling the quality and type of therapy given by the various disciplines.

For purposes of consistency, it is suggested that an individual with a medical background and training in psychotherapy have complete control and supervision over all staff doing treatment. In addition, I think the amount of staff alone does not ensure effective treatment. Numbers alone do not make for good therapy.

The quality of treatment must be maintained through in-service training in order to enhance needed knowledge and skills for the staff. There should also be consideration given to the use of professionals in the community, on a pro bono basis, to help deal with treatment problems and issues.

The New Jersey Psychological Association does have a pro bono group of volunteer psychologists who are willing to help. A number of years ago, Mr. Sager and I had talked about the possibility of having experienced psychologists provide some supervision to the staff, but somehow that fell by the wayside. We never had any further communication on that. An advisory panel of professionals could also be appointed to oversee

treatment on an ongoing basis. I am willing to serve on that advisory panel of professionals if needed.

Since the Diagnostic Center started, the prisons have increased staff who can provide treatment for sex offenders. Therefore, it is suggested that the Adult Diagnostic Center be closed and all sex offenders be placed in a prison with sections for diagnosis, a section for treatment, and a section for incarceration. In addition, there are always those individuals who could not benefit from any treatment or may require incarceration on a permanent basis.

For example, the geriatric offender could be placed in a secured unit of a geriatric facility such as Hagedorn or the Geriatric Psych Unit at Greystone Park Psychiatric Hospital. I can't see how you can treat 62 65-year-old men.

Those requiring incarceration on a more permanent basis could be placed in the Forensic Unit of Trenton Psychiatric Hospital or the Krol Unit of Greystone Park Psychiatric Hospital. Another possibility would be to have a long-term unit for sex offenders within a prison itself. All sex offenders could then have the opportunity for treatment.

If prisons are too overcrowded to accommodate a sex offender treatment section, then the use of existing facilities such as vacated, secured buildings at a State psychiatric facility might be considered, especially in view of the deinstitutionalization of psychiatric patients. What I'm really advocating is to try to take what is there and use it instead of throwing the baby out with the bathwater, so to speak.

Under legal headings, I think the sex offender law should be revised so that the determination of treatment would be made by mental health professionals rather than the legal profession. An indeterminate sentence could provide the needed time for treatment, help discourage inmates from cooperating with treatment in order to be released at a particular time, and

would take into consideration the unique makeup of each individual.

In other words, some people will go for treatment just to get their sentence reduced or to buy time in order to get out. They'll get themselves off the hook by saying, "Yes, yes, I'll go for treatment," but then they don't benefit from it.

Members of the legal profession should not interfere with or dictate the type of diagnostic instruments used, medication prescribed, and/or treatment given, which could be construed as practicing medicine without a license.

It is impossible to do effective treatment without knowing what is going on within the individual. Diagnostic accuracy is essential. Each sex offender should first be evaluated in a diagnostic unit.

This evaluation should include, but not be limited to, a complete psychological assessment that includes individual intelligence testing, neuropsychological evaluation in order to rule out neurological factors, personality testing, and vocational testing.

A psychiatric examination should include a Sodium Amytal interview, as originally permitted at the New Jersey State Diagnostic Center, neurological examination, Electroencephalogram which includes nasal pharyngeal electrodes or other means of reaching the limbic areas of the brain, and relevant blood work. The medical examination should also rule out any possible contributing medical conditions.

A psychosocial assessment would include family background, detailed medical history, previous hospitalizations, community and private resources used for treatment, present legal problems, history of acting out behavior, and educational history.

I might add that I think the confidentiality factor should be waived, and there should be communication between agencies, so that everyone has a complete picture as to what is

going on. We can't treat people unless we know what is happening with them. There has been too much, frankly speaking, confidentiality rules imposed that I think are-- I think a rule can be responsible and irresponsible in terms of adhering to certain regulations. I think if we're going to be helping people and treating people, we have to have an open system of communication. The right hand has to know what the left hand is doing, which, unfortunately, has not been happening as I can see it.

Treatment is determined by diagnosis and motivation of the individual. A variety of treatment modalities should be available because each person is unique, including life circumstances and offense. Some individuals may require psychotropic drugs or other medications and require the care of a psychiatrist, a neurologist, or a medical doctor depending upon the illness requiring medication.

Some inmates may consent to treatment in order to gain release and not to change behavior. There are others who will refuse treatment, as is their right under the law. Under the current law, a patient has the right to refuse treatment. You can't treat them. If they say, "No," you can't touch them, and if you try to do it, the Public Advocate will be on your back. So, right now, the patient has the right to say, "No."

Motivation to seek help cannot be mandated. If the inmate refuses treatment, then since a crime was committed, correctional treatment should be mandated. If a person has the right to refuse treatment, then I think the State has the right to take appropriate action. In any case, screening inmates for treatment, including an assessment of motivation for treatment, is essential prior to starting any treatment program.

Group therapy should be limited to 10 inmates per group, be of 90 minutes duration, and supplemented by individual therapy if necessary. There are some people who do not wish to discuss personal matters in a group. In such a case, individual

therapy would provide the opportunity for privacy and a more specific focus on personal problems.

A strict behavior modification therapy is not advised because any change is limited to the conditions under which learning takes place. This learning cannot usually be transferred to another place such as the community.

Classroom methods of teaching behavioral change, using books and other materials, do not appear to be effective because it is an intellectual approach which may not help the individual discover inner personality dynamics which are necessary for any permanent change of behavior.

Now, Senator Bassano had raised this question with me and I think it is a very important one. A modified 12-step program, similar to the one used by Alcoholics Anonymous, AA, appears to be most effective because it is based on self-examination, inner realizations, a real desire to change, and, in short, a transformation of character rather than surface modifications. Now, within the AA system you allow for individual variations. There are many forms of therapy that can be done within that.

Now, this is where we got into the definition -- Senator Bassano came up with this. Since the Sex Offender Act indicates that the behavior must be repetitive and compulsive, which is actually addictive behavior, a 12-step treatment program seems consistent with the needs of the Sex Offender Act. I think, Senator, you're right on target with that one.

Research is costly, and it is impossible to accurately assess the effectiveness of treatment due to the uniqueness of the inmate, the many people encountered in the course of treatment who have an impact on the inmate, salient variables -- which are those which can't be quantified, yet impact on the results -- and the personal attributes of the researcher. Often, when evaluation or planning type research is done, by the time the recommendations are implemented, the program being

evaluated could be obsolete because of changes taking place in the system or budgetary constraints.

When it comes to evaluating therapy, I don't know if anyone has been able to measure or quantify what goes on in a person's soul or in a person's heart. These are factors which are very important when determining therapeutic outcome.

As far as being obsolete, I think the State is very aware of programs which have sounded good on paper, but by the time they got implemented, they were already done with. It wasted a lot of the taxpayers' money, and frankly speaking, I'm a taxpayer and I am concerned about these issues, as well as a professional.

SENATOR BASSANO: Let me start off the questions then by asking you how important you believe it is that once a person is released from Avenel that they continue with therapy in the community.

DR. RISCALLA: Essential, but then the question becomes of monitoring them out in the community and getting the therapy in terms of the cost. It's not cheap.

SENATOR BASSANO: I think what this Task Force may be looking at is to establish a type of system where most people who leave Avenel would be paroled and not max out, as is happening now. With parole, there comes a certain control over the individual's life by the parole system itself. If we were to establish some type of help in the community for additional therapy, I just wonder how effective you think that would be?

DR. RISCALLA: Well, I have a problem dealing with mandated therapy; although, I had worked at Bergen Pines, which is before I went to the Diagnostic Center, and the judge referred people to me for court. I would sit down and tell them, "Look, you don't want to come to me. I don't want to treat you, but since we're both here in a bad situation, let's make the most of it." There may be a way of getting around that

to get them interested in therapy. It depends, again, on the therapist, on the person who is doing it.

I think you really need to sit down with the staff and get at what are their backgrounds, their qualifications, their motivations for working with a sex offender. Do they themselves have any problems or any hangups such as prejudices towards sex offenders? There are very emotionally charged things which have an impact on treatment.

ASSEMBLYMAN MIKULAK: I had a conversation with you. Your point of view is refreshing because you employ common sense, something bureaucrats -- you're not a bureaucrat, but I find that the bureaucrats--

DR. RISCALLA: I did my share when I was director of psychology, but I felt that--

ASSEMBLYMAN MIKULAK: Well, you're retired. (laughter)

DR. RISCALLA: Well, all the time I worked I wanted to keep my hand in working with patients. I felt that was important. I wanted to keep my feet on the ground.

ASSEMBLYMAN MIKULAK: One thing you said in your testimony which I agree with is that all sex offenders, not just those who have been judged repetitive, should have some type of treatment, because if they don't, they will be. If they're not in Avenel now and they're not getting treatment, they will be judged repetitive at some point.

Also, I'm wondering what you would think about an administration of an institution or a prison that, while it is being studied by the Legislature -- investigated -- changes the therapy mode, while we're looking into the therapy. What do you think about that? Do you think that is cooperating with--

DR. RISCALLA: I think therapy covers a wide range of definitions. I think incarceration can be very therapeutic. When a kid acts out, you send the kid to the room until he cools off. You lock him up for a little bit and then he comes back.

So I think when you're dealing with an adult, you have the same principle in incarceration, and that can be very therapeutic. Because they can't control themselves, they need somebody to stop them from acting out. Talk can be cheap. You can only talk so much, and then they're still acting out. You have to draw the line. When is enough enough already? Don't forget we have people out here, citizens, we have to look out for.

ASSEMBLYMAN MIKULAK: There are approximately 250 people in Avenel right now who have excessive terms, and to my knowledge, they're not receiving treatment, do you think they belong there?

DR. RISCALLA: I don't know. I guess in any population you might find those who don't. I think you have to maybe go through it and screen them out. We used to go through a procedure to find out. I think you need to evaluate your population, an ongoing evaluation as to where the people are in terms of treatment, and do they or do they not belong here. I think that is a team decision or up to the staff, and perhaps, the expertise of this Task Force can offer some guidance.

ASSEMBLYMAN MIKULAK: You alluded to the elderly people in Avenel and they certainly don't belong there. That is common sense.

DR. RISCALLA: Right.

ASSEMBLYMAN MIKULAK: The 65- or 70-year-old pedophile does not belong at Avenel.

DR. RISCALLA: Exactly, but who sent them there? It's the judge.

ASSEMBLYMAN MIKULAK: Right. So we have to look at-- What we're doing is looking at the laws. It's just unfortunate that the people who are running this program aren't more cooperative with this Task Force, because we're really trying to help straighten it out.

DR. RISCALLA: See, there had been a switch years back, historically, when Corrections and Human Services were

one. Then, for the old-timers -- maybe I'm dating myself -- there had been a break between Corrections and Human Services. At that time, Anne Klein ran Human Services. Mr. Fauver, I think, is one of the old-timers around. He really knows his stuff. But that is where the confusion came into play.

Now, you have sex offenders in jail, you have sex offenders at Avenel. That is why I am in favor of putting them all in one place, where they could all have the opportunity for treatment. But if they don't want treatment, then-- Look gentlemen, a crime has been committed. These guys have really committed a crime. The reality factor in terms of any treatment is that when you commit a crime you have to pay the price. This is society.

The same thing goes if you're going to have-- In terms of the atmosphere itself, you have to have a hospital-like setting. You cannot have such things as, frankly speaking, television sets, computers, all these great niceties, these amenities of life here. A lot of times I felt, as I looked around myself, I saw, "Hey, some of these people have it better than a lot of our poor, starving senior citizens do." I think this is a real situation that needs to be looked at.

SENATOR BASSANO: I think this Task Force agrees that a crime has been committed and a debt has to be paid back to society. We don't necessarily think that the entire prison sentence has to be at Avenel.

DR. RISCALLA: No.

SENATOR BASSANO: What we may well recommend, and we will discuss it among ourselves, is a dual type of sentencing where a person is going to serve a certain portion of their sentence doing hard time, making Avenel into the place where people will get rehabilitation. It makes little sense for 250 people, or whatever the number may be -- I just used 250 as a figure -- refusing therapy and taking up a bed at Avenel when it

is supposed to be a facility for treating these people before they go back into society.

DR. RISCALLA: I think therein lies the fact that I don't have a punitive outlook. I think that you have to look at, prison can serve a therapeutic purpose. It protects the person from hurting themselves by committing crimes. It protects society from being hurt. So I think if we have a-- If we stop looking at it from a punitive standpoint and saying, "You have to pay. You've got to pay," and chop off heads, so to speak, or an eye for an eye or a tooth for a tooth, but look at it from the standpoint, as I had said in an article years ago, as a crisis intervention center.

England has prisons that are set up therapeutically as crisis intervention centers, where people can go to be protected from themselves, where society is protected, and they can get some kind of help to control their impulses. You know, the head can say one thing but the emotions will say another. You have to get the two working together, and all this book learning is not going to help a soul. It has to get down deeper than that.

ASSEMBLYMAN MIKULAK: You're right.

MR. THOMAS: Doctor, do you feel that there is any hope for a pedophile when he reaches adulthood?

DR. RISCALLA: I don't know. That's the big thing, you're dealing with unknown quantities. It's hard to say.

MR. THOMAS: I have talked to any number of doctors across the country and none of them have said, "Yes, there is. There is a very small percentage that, perhaps, could be helped but not (indiscernible)--"

DR. RISCALLA: I've heard that also.

MR. THOMAS: So, if they're not cured, how can we release them?

DR. RISCALLA: You can't.

MR. THOMAS: Okay. Thank you. One other question.

DR. RISCALLA: I've heard the same thing, too. I've heard the same thing said about sex offenders, quite frankly, from professionals. Do you know why? Because it's a pleasure principle. It makes a person feel good. The pedophile, he feels good, the sex offender feels good. You're dealing with very powerful emotions here. Sex is one of the most powerful drives of humanity. As matter of fact, it's a procreative drive, but it has gone amuck.

MR. THOMAS: And it's not like the alcoholic or the drug abuser where something foreign has to be introduced into the system. The desire is always there.

DR. RISCALLA: No, but some people are addicted to sex. I think we had that conversation, Senator Bassano, about that.

SENATOR BASSANO: The only place where it's on an even plane is the fact that it's an addiction.

MR. THOMAS: That's right.

SENATOR BASSANO: I'm not too sure that an addition can ever be cured. As you mentioned, I think you can control it, but I'm not too sure it can ever be cured. But I'm not the expert.

DR. RISCALLA: The alcoholic never says he's cured. That's where I think it's very important. But a lot of these fellows, they don't think there is anything the matter with them. That's the problem.

SENATOR BASSANO: Senator McGreevey had a question.

SENATOR McGREEVEY: Clearly, the culpability also resides with the courts--

DR. RISCALLA: Yes, and how.

SENATOR McGREEVEY: --as well as the Department of Corrections, insofar as the courts have within their discretion to confer a punitive aspect to the sentence, as well as a diagnostic or treatment element.

Just to follow up on the question, in your experience in terms of sentencing, not only in terms of making a clinical diagnostic decision, have the courts been responsive to the punitive aspects of sentencing for sex offenders?

DR. RISCALLA: I can't answer that because I haven't worked in a sex offender unit in some time. I can only answer from the standpoint of my work with the Krol's. Well, we've been doing-- Memos have gone out to the courts to educate the prosecutors. I think this might be a thing to talk about to the legal profession. Sometimes, they've gone along with it, but many times I've had to sit there with a judge and tell him, "Look I can't. This guy is--" I have to prove dangerousness. If I can't prove dangerousness then the person has to go out.

So the result is you're finding a lot of dangerous people out there in the community. No wonder you have a lot of ex-mental patients committing crimes, because the courts have forced the professionals to release them.

SENATOR McGREEVEY: But, I guess, just to go to the methodology of sentencing--

DR. RISCALLA: That would be sex offenders, too.

SENATOR McGREEVEY: Just to go to the methodology of sentencing, and a certain aspect is more appropriately asked to the Department of Corrections, but basically, prior to ADTC and I'm sure today, you were charged with the responsibility of treating certain offenders. Is that correct?

DR. RISCALLA: Pardon?

SENATOR McGREEVEY: You were charged with the responsibility of treating certain offenders?

DR. RISCALLA: Who is?

SENATOR McGREEVEY: Your role, your function, you helped to treat certain offenders.

DR. RISCALLA: I didn't treat these-- I worked with the Krol patients, some of them were offenders. But my original job was diagnosing them.

SENATOR McGREEVEY: At what point--

DR. RISCALLA: That was part of a team approach.

SENATOR McGREEVEY: Okay. But at what point in time was a decision made by the center as to the treatment levels or the relative success or failure of the treatment?

DR. RISCALLA: I think you would have to ask that of the staff of the Diagnostic Center, because I'm not qualified on that. The only thing I could say is that from the standpoint of mental health, in general, the Krol patients -- those are judged not guilty by reason of insanity-- I think the courts need to, frankly speaking, stop practicing medicine without a license. They are making medical and psychiatric decisions, and as a result, you have a lot of ex-mental patients committing crimes. So you have to get it together, you know.

SENATOR McGREEVEY: This is my last question. I guess the heart of grave concern is that the courts, in certain instances, are making a preliminary decision which has an impact on the inmates or the convicted felons, not only terms of incarceration, but the type of incarceration.

DR. RISCALLA: Yes, the courts are the ones who make the-- The team may make a recommendation to the court, to the judge. It is up to the judge and the court to decide whether or not that decision will be implemented or not, and law has certain specific requirements.

In other words, they might-- In terms of general mental health, you have to prove the person is dangerous to self and/or others. If you can't prove that, that person is released.

SENATOR McGREEVEY: It's absurd.

DR. RISCALLA: Now, in a structured setting, you can't prove dangerousness because they're medicated and they're under control. How do I know what a person is going to do out in the community? Yet I am forced, as part of the team, to say, "Let them go."

SENATOR McGREEVEY: So the system is fundamentally flawed?

DR. RISCALLA: If I don't, I'm in contempt of court. I'm the victim -- I mean, I'm the criminal then.

SENATOR McGREEVEY: Thank you.

SENATOR BASSANO: Assemblywoman Wright.

ASSEMBLYWOMAN WRIGHT: I just have a technical question.

DR. RISCALLA: There is such a thing as victim's rights here people.

ASSEMBLYWOMAN WRIGHT: Mr. Chairman, since Dr. Riscalla has an extensive background in publishing, as well as her expertise, I wonder just in general today if we could have curriculum vitae on the people who do testify? I would ask that for all of them. Because one of the things we're doing is reviewing some of the literature, I would be interested to see if she happens to have some publications we would want to see. I would ask that for all of the speakers to follow. If we could ask them, at some point, to submit to the staff their curriculum vitae so that we can at least--

DR. RISCALLA: I'm a little bit-- I'm just recovering from a bug. Assemblywoman Wright, I didn't quite understand or hear.

ASSEMBLYWOMAN WRIGHT: I'm asking the Chairman to request your curriculum vitae.

DR. RISCALLA: I sent one to Anne Stefane.

ASSEMBLYWOMAN WRIGHT: Fine.

MS. STEFANE: Does that have all your publications on it?

DR. RISCALLA: I don't know if you have a list of them, but I also gave Senator Bassano a few of them. But I don't know exactly which ones--

SENATOR BASSANO: Some of what the doctor published I asked to be sent out to the Task Force members, but feel free to ask that question of people.

ASSEMBLYWOMAN WRIGHT: I'm just asking it-- This is a technical question as it relates to all people who testify today, if we could have their resumes. Basically, I want more than their one-page. I see that there are a number of people who are professionals, and if we just ask everyone who testifies today to send us something for the record--

You have already done it. Thank you.

DR. RISCALLA: Speaking of resumes, do you have resumes of all the staff of the Diagnostic Center? I think that would be important for everyone to have.

ASSEMBLYMAN MIKULAK: We'll ask Mr. Plantier to provide that when he comes up next.

DR. RISCALLA: Mr. Plantier and everyone on the staff, I think that is important to have, to help them out.

ASSEMBLYMAN MIKULAK: He hasn't been that cooperative with us to date.

SENATOR BASSANO: Assemblywoman Crecco.

ASSEMBLYWOMAN CRECCO: Thank you.

Doctor, one thing, I just appreciate you being here and commend the Chairman for inviting you, because you're really giving us not just insight, but a lot of honesty.

I wondered, since we have these sex offenders, would you suggest that most of those offenders were juvenile sex offenders probably prior to being adult sex offenders? Would it be in our interest to have treatment centers for juvenile sex offenders to possibly avoid this later in the future, as a preventative?

DR. RISCALLA: Yes, I have a seen a number of juvenile sex offenders, and frankly speaking, the kids can be worse than the adults just simply because they're not formulated. Their brain capacity, their reasoning, they're not developed

emotionally, physically. Otherwise, they're running on primitive energy, frankly speaking. I think, perhaps, they might need to have a special place for themselves. Their acts can be-- I think you may hear in some of this testimony that their acts can be just as vicious if not more so than the adults.

I've had the unfortunate opportunity of being struck by a child and I still bear my scars. I like working with them. I really enjoyed my job and I enjoyed working with the State. But the outlook for them is dismal because the offense is committed in their developmental stages, and then they get conditioned.

ASSEMBLYWOMAN CRECCO: But if we have treatment centers for these juveniles, do you think this would be in the area of preventative of future sex offenses?

DR. RISCALLA: Ideally, yes. But would the taxpayers be able to support the bill is another question.

SENATOR BASSANO: I think, Marion, one of the things that we--

DR. RISCALLA: These are costly.

SENATOR BASSANO: --may well want to recommend is that there be a group established -- legislative, public, a combination of both, or whatever -- to specifically look at that issue. The Governor just issued a report on juvenile justice and I think we may want-- Maybe that group would take a look at that report and then take a look at this particular subject. I don't necessarily know that we are charged to get into the juvenile offender. As much as I would like to, I think it may take away from what we are trying to accomplish with Avenel.

DR. RISCALLA: Just as an aside, they're throwing out the baby with the bathwater. It just dawned on me as we were talking, Al Vuocolo, at one time-- There was a juvenile offender unit right across the street from the Princeton Developmental Center and that was for boys. It was a very

secure setting. Now, I don't know what has happened to that. Maybe some of these places could be used for these purposes. I think we have a lot already, we just need to tap into the resources which are already there.

ASSEMBLYWOMAN CRECCO: Mr. Chairman, I only asked that because we have so many problems with the adults. I was thinking that if we had more treatment for the juveniles sex offenders which I had suggested--

SENATOR BASSANO: I think we're really going to have to look at that subject, Marion. Maybe what we're going to have to do is put something in the report on that subject as to where the Legislature should go. I just don't know if we should be getting into that because that is not what we were charged to do. I recognize that it is probably as important if not more important than what we're dealing with, because these people are future adult offenders if they're not cared for now.

DR. RISCALLA: That's right. A lot of them have committed crimes and have already-- Talk about the confidentiality, a lot of them have committed crimes as juveniles, but then the adult version -- but we don't have access to that information. We have already found out how tragic that has been.

SENATOR BASSANO: Peter Inverso is next, and then John.

SENATOR INVERSO: Doctor, first, hi.

DR. RISCALLA: Hi.

SENATOR INVERSO: Thank you for giving us some of the historical perspective. I'm just curious, when you were associated with the Menlo Park Diagnostic Center-- What is there that is different about what is happening today in Avenel versus what was happening at the Diagnostic Center during your tenure there? I understand there may be therapeutic advances, that there may be innovative, creative, new ways of approaching psychotherapy and so on. But in terms of admission and

evaluation, in terms of the type of treatment that was given there, therapeutic treatment -- without getting into the degrees of the therapeutic treatment -- and then in terms of how one left there, and what information you know of regarding the recidivism rate of those who went through that program as opposed to Avenel. Because, obviously, a decision was made that Avenel could do it, the presumption that-- What could you give us that would help me make a comparison as to what was there, what we have now? The main reason we're here is to determine if Avenel is achieving its mission.

DR. RISCALLA: Well, two things. One, I think that the prior history-- Albert Ellis, one of the most renowned psychologists in the country, had been the chief psychologist in the State at the time, and this was his baby. Dr. Ralph Broncale has passed away. We had a medical director. We had the assistant superintendent. We were following a medical model pretty much there. We didn't do any treatment, it was strictly diagnosis.

SENATOR INVERSO: So the Diagnostic Center was strictly that?

DR. RISCALLA: Strictly diagnosis. In terms of diagnosis, they did Sodium Amytal interviews, and the Public Advocate came along and said, "You can't do that any more."

SENATOR INVERSO: Well, let me ask you, if you could just take me through it from a pragmatic--

DR. RISCALLA: Pardon?

SENATOR INVERSO: Just take me through pragmatically. Someone was, I guess, referred to the Diagnostic Center.

DR. RISCALLA: By the court.

SENATOR INVERSO: By the court. You then went through and diagnosed?

DR. RISCALLA: Diagnostic evaluation on a team approach.

SENATOR INVERSO: What were the outcomes of that? What were the potential outcomes of that?

DR. RISCALLA: Then the report would be compiled. We had a team approach. We had a psychologist, social worker, physician, we had a electroencephalographer.

SENATOR INVERSO: But where did the individual go once they were diagnosed?

DR. RISCALLA: The individual was then-- For instance, if a person was referred to jail, came from the jail, they would go back to jail. The report would then be sent to the judge, and the judge would determine what would go on from there.

SENATOR INVERSO: But what you were doing--

DR. RISCALLA: I never saw them after they were diagnosed.

SENATOR INVERSO: Right. So you don't know after they were diagnosed what kind of treatment--

DR. RISCALLA: The outcome, no. I didn't even know whether treatment was implemented or not.

SENATOR INVERSO: Exactly. So that is why at some point in time it was determined that Avenel, an institution like Avenel, would achieve some results. Because once a person was diagnosed, no one knew what the follow-up was, what the outcome was.

DR. RISCALLA: Well, the reason for the Avenel setup, as I understand-- One person to answer that would be Bill Plantier, because Bill was a teacher at the time I was on board at the Diagnostic Center. So he could answer you the contrast between the two.

My understanding that the reason for Avenel was because the sex offenders were getting beat up in prison, that they needed a place where these men could go. They're at the bottom of the heap. So they couldn't put them in a regular prison population because they would be getting beat up, and

their lives would be in jeopardy from the other prisoners. The other prisoners considered them the scum of the earth, so to speak.

SENATOR INVERSO: But do you think that is a valid reason for continuing the facility at Avenel, that that reason is valid enough to continue it? Or does the therapeutic approach that Avenel should be applying, is that the reason?

DR. RISCALLA: Well, I don't see why it can't be done in the prisons themselves. I really don't. From what I heard, I mean this can be borne out-- As I said, you have staff from Avenel who can answer many of these questions much better than I can. My understanding is that Avenel is pretty overcrowded, and I don't know how much you can accomplish in such an overcrowded situation.

SENATOR INVERSO: Clearly, they're not accomplishing what they should be accomplishing. It is a question of: Have they been given the appropriate resources and support to do that? That is another issue apparently.

DR. RISCALLA: I don't know what kind of diagnostic tests are being given either or the medical set up there.

SENATOR INVERSO: Okay. This is a question you can't answer. If your proposition is that they should go into the general prison population with some degree of segregation, but then some, obviously, application of therapy the question is: Is that more cost-effective? Will it have a better result than what we are seeing out of Avenel now? I don't know the answer to that.

DR. RISCALLA: We have to bear in mind, folks, that a crime was committed.

SENATOR INVERSO: That's right.

DR. RISCALLA: Let's not forget that fact. I think that prisons themselves have been moving ahead in terms of their mental health, their staffing. They have wings, they have

sections there, the prisoners there-- They have certain sections for different types of offenders, as I understand it.

SENATOR INVERSO: Right. Clearly, there is a perception about Avenel right now, which may be borne on some degree of reality, that it is kind of cozy and soft and that there ought to be less of that, more intensive therapeutic applications, and also, maybe, more of a punitive aura about the facility. That is something that we have to deal with, certainly. We'll deal with that. But there is no question, a crime has been committed, and there is no question that the person should pay for their crime.

I'm just pursuing this questioning with you because, clearly, you favor, in essence, disbanding Avenel and moving these individuals into the general prison population with the allied therapeutic intervention and so on in the general prison population.

DR. RISCALLA: There might be more room and you can treat everyone there.

SENATOR INVERSO: Well, the prisons are overcrowded right now. We're waiting for Bridgeton to begin.

DR. RISCALLA: Well, then you have the other, the deinstitutionalizing of the other facilities. Instead of letting these buildings go to rot and to pot, see what you can do with them.

SENATOR INVERSO: Question. Now, Assemblywoman Crecco raised this, and this is a concern of all of us, about the approach towards juvenile offenders, obviously, if there is any hope for any rehabilitation, and that question is still out in terms of the jury on that question. But we need to do more with juveniles. Now, we have the Pinelands Program down in South Jersey.

DR. RISCALLA: That sounds good.

SENATOR INVERSO: Yes, it sounds very good. Probably we need to replicate more of that and improve that. But, in

your opinion, is there hope for rehabilitation with juveniles vis-a-vis adults, or is that just a hope or a wish that we have? The question of whether someone has this behavioral problem -- it's a compulsion, it's addictive -- does it ever, ever get cured?

DR. RISCALLA: Well, we never speak of a cure for that, we speak of remission. I spoke to Joanna Scocchi some time back, and Joanna had suggested this idea of a boot camp. You know, we were talking about the boot camp idea and I think it's a very good one. She had some very good ideas about it.

You need some consistency. You need some discipline. I don't mean banging heads on the wall or anything.

SENATOR INVERSO: I guess the bottom line is, if we have a juvenile offender and we deal with that, there is no cure, is that individual confined to the State's control and responsibility for the rest of their life?

DR. RISCALLA: Some may be, especially if you have those who have organic problems. I don't want to give up hope. I think that we should always keep an open mind. I think hope is a mistake, but I believe in being open-minded and to try. But I don't want to say that, "So and so is hopeless." I would say that, "The likelihood of--" If this person has an organic brain problem and that brain problem contributes to it, I don't think there is anything you can do, because no one has yet told me how we can toilet train a child without having a sphincter muscle, so to speak.

SENATOR INVERSO: But, clearly, intervention is warranted and-- But it is something that maybe, as Senator Bassano alluded to, almost like a lifetime parole situation.

DR. RISCALLA: Yes. How many times, gentlemen, do you hit your head against the wall without getting a fractured skull? You have to know when to stop banging your head, and that's a hard question.

SENATOR BASSANO: Well, I think, taking it one step further, I said this before, we're going to have to recognize that some people should never go back into society.

DR. RISCALLA: Right. There are some people, frankly, that you have to lock up and throw away the key. I think this is a very hard thing that people don't want to face. In the mental health field we want to cure everybody, but we can't. We have to know our limits.

SENATOR BASSANO: We'll let them out only if they run for the Legislature. (laughter)

DR. RISCALLA: I don't want to go from one extreme to the other but we have to know--

SENATOR BASSANO: Senator Girgenti.

SENATOR GIRGENTI: Doctor, I'm very impressed with what you said earlier. I just want to ask you a couple of questions. More or less one of the things was a follow-up of what Senator McGreevey said. The team would recommend to the judges what should be done? You're saying the discretion is there, and they have kind of countered the recommendation?

DR. RISCALLA: Sometimes, yes.

SENATOR GIRGENTI: You feel that this is probably, as you said before, one of the main problems we have here?

DR. RISCALLA: Yes.

SENATOR GIRGENTI: Basically, there is the discretion, and with this discretion, they have just seen fit to go the other way, even sometimes countering the decision of the diagnostic people?

DR. RISCALLA: Yes.

SENATOR GIRGENTI: Another thing, and I don't want to--

DR. RISCALLA: I'm not trying to blame the judges or anything. I come from a family-- I'm a third generation in the State. My great-grandfather was a judge. My mother worked in the Probation Department. So I have a great deal of--

SENATOR GIRGENTI: I understand. I understand that. But you're saying that maybe if somehow the discretion was taken away to some extent in what the recommendation was, it would probably be more in sync of what you're trying to advocate.

DR. RISCALLA: Yes.

SENATOR GIRGENTI: All right. The other thing is--

DR. RISCALLA: Keep it in the hands-- If you're going to be talking about diagnosis and treatment, then keep it in the hands of the professionals who are doing it.

SENATOR GIRGENTI: The experts.

DR. RISCALLA: Many times, folks, I've recommended correctional treatment for people in my recommendations. I've heard those recommendations made.

SENATOR GIRGENTI: All right. Now, I've heard what you've been saying in terms of Avenel. One thing I've-- Of course, I don't declare myself an expert on this; I've only been through the facility twice now, once really touring it. I see a lot of -- maybe this is my impression, I think other people have it-- There seems to be a lot of free time, a lot of people just really laying around on bunks. I heard statements at our last hearing that maybe there was an hour and a half of therapy a week. There was a lot of free time was emphasized.

What exactly-- As you said, what is being accomplished here that could not be accomplished in a jail, really, or in a prison?

DR. RISCALLA: What happened to the work details? I recall years back, one of the saddest things I encountered was when-- The prisoners from Rahway used to come over to the Diagnostic Center and clean out the offices. One day, one of the prisoners said to me, "I'm not coming back again." I said, "What happened?" He said, "I can't come back any more." I said, "What did I do wrong?" They were talkative kids. They were really wonderful guys. The Public Advocate came in and demanded minimum wage. The State couldn't afford to pay these

guys minimum wage, back to prison they went, and what happened to them, I don't know. So now I wonder what happened to some of these work programs.

What about GED programs? At one time, they did have an educational program there.

SENATOR GIRGENTI: Like I said, I saw a lot of computers, I saw a lot of TVs.

DR. RISCALLA: There are a lot of things that can be done, but you have to look out for the-- The Public Advocate came along one time and said, "No, you can't do these things."

SENATOR GIRGENTI: That has been disbanded at this point.

DR. RISCALLA: They had vocational-- They had work programs that were disbanded because the Public Advocate said, "Come on, you've got to pay minimum wage." We can't afford it. The people are winding up laying around the wards.

SENATOR GIRGENTI: I think if you look at that, and I don't think there is really an intensity there in terms of-- It looked like a very relaxed atmosphere to me, and that was in my impression of what this program should be all about. Of course, again, I'm a layman.

But, you know, when I hear "an hour and a half a week" and this other stuff, to me that's not achieving anything, in my opinion. It's just I don't think it can be productive. I think you probably-- When you say things that you said in terms of this, "This could probably easily be done inside the prison," you're probably right. I don't know what they're accomplishing at this place. It looks like it's almost the idea of a country club or a place where you can go and flop out and relax. I don't see that as punitive at all, quite frankly.

DR. RISCALLA: Work is very therapeutic and helps prepare people to get out in the community. You need to give them work. You have to train them. By the way, I have a rehab background. You have to train them in marketable job skills and

give them on-the-job experience, not Basket Weaving 101 so to speak.

SENATOR GIRGENTI: Right. I think you're on the right track. We have a bunch -- 30 percent of the people in this program have refused to even take treatment and they're still here. I don't understand. Why wouldn't they be put right back into prison?

SENATOR McGREEVEY: Send them to jail.

DR. RISCALLA: You have to ask that question of the powers that be. I can't--

SENATOR GIRGENTI: It's just amazing to me.

DR. RISCALLA: This is my recommendation.

SENATOR GIRGENTI: One of the bills I've been pushing, and I know we passed, is lifetime parole. I think that is important. We should never lose touch of these people in the process because we've seen too many times where people have slipped through the cracks, even once they're out. After they're out, they go to another state or somewhere, come back into New Jersey, and we have no record of them. So we do need a constant handle and a constant control over these people, lifetime.

DR. RISCALLA: This is one of the aspects of the confidentiality that I was talking about. Now, how about people such as the Kankas? What kind of prison are they living in for the rest of their lives?

SENATOR GIRGENTI: You're right.

DR. RISCALLA: And the other people who have been offended by the sex offenders, these people are in another kind of prison for the rest of their lives.

SENATOR GIRGENTI: You're absolutely right.

DR. RISCALLA: Tell me, folks, who is treating these people? We're talking about treating of sex offenders, but how about the one who has been offended? What resources are

available for them? I think we also need to look at this aspect too.

SENATOR GIRGENTI: I want to thank you.

SENATOR BASSANO: Are there any other questions before we go on to the next speaker or group of speakers?

Yes, Jim.

SENATOR McGREEVEY: Just a last question. So what you're saying, succinctly, is that you would be in support of the abolishment of Avenel in its present form, and return that to a function of a custodial prison site?

DR. RISCALLA: Right, especially in view of the progress made. I think that the staff could be relocated. I think you have enough staff that they could be-- You wouldn't be having to result in any layoffs. I would hope not, anyway.

SENATOR McGREEVEY: Lastly, as Senator Girgenti and Senator Bassano mentioned, for those individuals who refuse treatment, what would be the appropriate mechanism which you would design to respond to that? For those inmates who refused treatment?

DR. RISCALLA: Prison, incarceration.

SENATOR McGREEVEY: No, but if we were to remove it to prison then it would just--

DR. RISCALLA: As I said earlier, you would have a separate unit for incarceration. You could keep them on it. You could keep them away from-- You would keep them in the incarceration unit, then maybe they might decide at some point.

SENATOR McGREEVEY: Thank you.

DR. RISCALLA: But you have to keep a focus there on, "Look guys, you fouled." They have to come to the realization that they are sick and in need. But right now, tell me what is the incentive, where is the motivation?

SENATOR McGREEVEY: There is none.

DR. RISCALLA: What is the incentive out there to prevent such crimes?

ASSEMBLYMAN MIKULAK: I would like to ask OLS to work on a model. I think 40 percent of the sex offenders are now in Avenel, the rest are disbursed throughout the prisons. I would like OLS to work on a model if there was no Avenel, you know, some kind of cost/ratio benefit. Provide everybody with therapy, everybody should get therapy. I asked Corrections who was getting therapy, and they had a hard time answering in the different prisons because it's not standardized.

DR. RISCALLA: Well, see there is therapy and there is therapy. You can throw 25 guys in a room with a therapist and say they're getting therapy, and say on paper, "Hey, look, all of these men are getting therapy."

ASSEMBLYMAN MIKULAK: We're going to be meeting soon and making recommendations as a Task Force. I would like OLS to prepare some type of cost analysis and model, life without Avenel, so we can see it as an option.

DR. RISCALLA: I would be willing-- Again, if I can be of any help to anyone here, I throw in my time and my expertise to be of benefit to the Task Force.

ASSEMBLYMAN MIKULAK: Thank you very much.

SENATOR BASSANO: Are there any other questions?

SENATOR MATHEUSSEN: My only comment would be, if we are going to have OLS look at that, I would think we would also want OLS to take a look at what it would cost in a model to have Avenel brought up what this Task Force might think it should be operating as. I don't know if we could know the answer yet.

SENATOR BASSANO: I don't know if you can do that until we make a recommendation.

SENATOR MATHEUSSEN: That is correct.

SENATOR BASSANO: I think that--

SENATOR MATHEUSSEN: I'm not convinced that the abolition of Avenel is the correct--

ASSEMBLYMAN MIKULAK: I'm not either, John.

SENATOR BASSANO: I agree with you, John. I think that maybe what the Task Force would want to look at and then look for a cost factor in, making Avenel into an institution where extensive therapy is given prior to people going out on parole and downsizing the number of prisoners who are there right now, so that it becomes an effective institution. Then, maybe following the Doctor's recommendations where sex offenders will spend time prior to coming to Avenel some place in the penal institution isolated in a certain wing or a certain area, and maybe even looking at trying to get some of those folks who are at Avenel a little bit more productive.

If a person is getting five, six, ten hours, or twenty hours a week, whatever it may be, of therapy they certainly still have too much time on their hands. So that is something that we may want to also talk about.

DR. RISCALLA: Years back -- I'm sorry I don't mean to interrupt -- I wrote an article on a rehabilitation model for Corrections. I read it and I thought I would still believe that today. I don't know if I gave that to you or not, but it is based on a rehabilitation approach to corrections, and I think it would have relevance to Avenel as a perspective of how we look at things.

SENATOR INVERSO: Mr. Chairman, if I might?

SENATOR BASSANO: Peter.

SENATOR INVERSO: So what I'm hearing you say is that we're going to have several scenarios developed, several models developed?

SENATOR BASSANO: Yes.

ASSEMBLYMAN MIKULAK: Right.

SENATOR INVERSO: Could this Task Force then, at some point after the hearings, agree on which models should be approached?

SENATOR BASSANO: Yes.

ASSEMBLYMAN MIKULAK: Right.

SENATOR INVERSO: I think I agree with Senator Matheussen. I wouldn't foreclose anything right now, because our Task Force has not reached a conclusion one way or the other. I do think there are alternatives and there are models that should be pursued, and if we could agree on what those scenarios are, then we can all have OLS kind of develop them and then make our assessments.

ASSEMBLYMAN MIKULAK: Right.

SENATOR BASSANO: What we will do, Peter, after we conclude our hearings, is meet as a Task Force and then lay out the direction we think we should be going in. Then, we can ask for cost analysis at that point.

SENATOR INVERSO: Good. That's the approach.

ASSEMBLYMAN MIKULAK: One of the shocking facts I learned in asking Corrections-- They have approximately 60 percent of the sex offenders disbursed in these other institutions. I asked them what kind of therapy they get, and they can't answer. So we have time bombs out there. Just because they haven't been judged repetitive yet, doesn't mean-- They probably will be in the future if they're not reached. So we have to look at standardizing.

DR. RISCALLA: This is an arbitrary law, by the way.

SENATOR BASSANO: One of my recommendations to this Task Force will be to get rid of that part of the statute and leave that discretion up to the professionals and a judge in sentencing. A person should not have to commit a crime two, three, or ten times before they are sentenced to Avenel. If they are potentially dangerous, it's judged by the medical community that they are and the courts agree, then they should definitely be getting treatment.

DR. RISCALLA: See, the reason is, right now the current Sex Offender Act is very arbitrary. The judge defines it. So, as a results, you have sex offenders scattered in prisons and in Avenel. So I'm for having them all under one

roof, so to speak, where they can all get the benefit of treatment.

SENATOR BASSANO: Let's see if we can move forward.

Doctor, thank you for your testimony.

DR. RISCALLA: My pleasure.

ASSEMBLYMAN MIKULAK: Thank you.

SENATOR BASSANO: Superintendent Plantier, if you and your group of people would be kind enough to come forward?

Mr. Sager, do you want to bring Dr. Graffin up with you also? (affirmative response)

For those members of the Task Force who may have missed our first meeting, Bill Plantier and Wayne Sager were before our Task Force at our first meeting. I've asked them to come back in light of the fact that they've made some changes at Avenel. I know that there are a lot of questions that have come about because of those changes, so why don't you folks start? Maybe you can explain to us what you did, why you did it, etc.

W I L L I A M F. P L A N T I E R: Okay. I think that is very fair. What happened back in September of 1991, the treatment staff -- the psychology staff as a whole -- sensing a great deal of dissatisfaction with the way their therapy programs were running, their caseloads, how things were being managed in terms of the treatment program, had requested and received approval to form a team, a review subcommittee, so to speak, of the treatment staff.

At that point, they began meeting intermittently, studying other programs that were out there in the United States, and as a part of that, two members -- including Mr. Sager and Assistant Superintendent Rogers, who is sitting here with us -- with an NIC grant went out to the Boulder, Colorado to the National Institute of Corrections. There they attended a program for sex offender treatment programs. As a result of the discussions they had with colleagues out there and viewing

other programs out there, they brought back some recommendations which went to this review subcommittee.

As a result of that meeting, also, we received an NIC grant and, in May of 1994, had Dr. Nancy Steele come out for a week and evaluate the program. Dr. Steele's report has been provided to this Task Force, as well as the other documents that were relevant to this.

As a result of all that review going on, it was decided to, basically, change the structure of how the treatment is offered. We didn't change the program and I think that is a fallacy that people-- There is a misconception out there that the program has been somehow radically changed and that we're doing things radically differently.

SENATOR BASSANO: Who gave the permission to do that?

MR. PLANTIER: The permission was ultimately received from Commissioner Fauver in December of '94, based on a report I sent him after my discussions with Chief of Staff Hilton regarding our request to make some modifications.

ASSEMBLYMAN MIKULAK: Did you think that this might have been of some interest to this legislative Task Force?

MR. PLANTIER: Oh, completely.

SENATOR BASSANO: Shouldn't we have been told when you came before us the first time?

MR. PLANTIER: Well, to be frank, Senator, we weren't sure when we were going to go ahead with it. I do believe I alluded to changes in the program.

SENATOR BASSANO: No. You alluded that you were getting more staff. You didn't allude that you were going to change the program.

ASSEMBLYMAN MIKULAK: Vaguely. You made vague reference to some future changes, but when it became specific-- We had a meeting in your institution on December 6. I have the memos now from December 7, from Grace Rogers to William Plantier, and December 8, from William Plantier to Gary Hilton.

MR. PLANTIER: Exactly. If I may explain that? My understanding from my superiors on your Task Force meeting on the 6th was that I was to stand by and to meet with you at the end of the meeting. Myself, Mr. Sager, Ms. Rogers, and others all did stand by to meet with you because our understanding was that you were going to ask us questions. We were fully prepared to talk about it at that time. Without our knowledge, you broke and you left--

SENATOR BASSANO: But you should have told us about this when you were testifying. I had no idea that this was going to happen. I couldn't have come to you and said, "Are you making changes?" It should have been part of your testimony.

MR. PLANTIER: Well, frankly, I'm answering questions, and since I don't have a date for when we were going to begin when I testify in early November, and it's not raised, and I have an understanding I'm going to be meeting with you again in early December, I figured it would be raised at that point.

But, ultimately, I would have felt that it was the goal of my superiors to notify you of these changes. If that didn't happen, then I can certainly apologize, but that would have been my understanding as Superintendent in my chain of command.

ASSEMBLYMAN MIKULAK: Mr. Plantier, do you think we, the Task Force, should have been notified by the Associated Press of these changes?

MR. PLANTIER: No and I find that quite unfortunate.

ASSEMBLYMAN MIKULAK: Well, that's what happened. I think it's unfortunate because we're not here to hurt you, you know. We're not here to hurt this program. We're here to look at it and see what is-- You know, the very changes that you're contemplating are of extreme interest to the Legislature.

MR. PLANTIER: Well, I would be very willing to explain them to you. I can't help how the chain of command

operated and what wasn't communicated, but I was prepared to talk about it.

ASSEMBLYMAN MIKULAK: Okay. I have a few questions. On December 8, in your memo-- Okay, I'll let you finish your testimony. I have a number of questions on the memos.

MR. PLANTIER: On the basis of that review and a final report to me, I wrote and I spoke to Assistant -- excuse me -- Chief of Staff Hilton, who, again, spoke to the Commissioner, and I received a written letter back from the Commissioner telling us to proceed and to provide him with 90-day periodical updates of how the changes and revisions are going. With that, at Christmastime, we did proceed with the changes in the treatment staff that we had foresaw.

I would like to point out to you that while we have discussed treatment to some degree, we have never really discussed treatment in terms of all its intricacies, how groups run, and when they run. We didn't go about abandoning any programs. We didn't go about just throwing out the whole program and beginning with something new.

We took the recommendations of all these people, with the resources that we had available to us, and basically, tried to restructure the program in a way that we would get better service for the staff that we had available, provide good treatment for the inmates, and hopefully, when this is all said and done and implemented, more treatment for the inmates than they have presently available.

So it wasn't like we changed philosophically and said, "This doesn't work anymore. We're going to try something different." What we basically did was take the structure that we had and modify it to try and make it better serve our needs, and what were addressed are the needs of the inmates. So it was an internal change.

I would not want, for a moment, for any of you to think that the philosophy of Avenel has changed. Our goals have

not changed. The way people get out does not change. I mean, those things are all still in place. It's just mechanically how we utilize our staff in house that has changed.

Hopefully, what we're going to do, and certainly, Dr. Graffin and Mr. Sager can explain the details better, what we're, hopefully, going to provide is a better type of therapy, a more meaningful type of therapy, and more therapy experiences for the current population at Avenel.

But we're at a very, very early stage of the process, and I wouldn't, by any sense, want to tell you that this is working great, this is working awful; it's too early to tell. We're still bringing programs on-line as we speak.

SENATOR BASSANO: Do you think it was wise to reorganize while this Task Force was meeting on the very subject?

MR. PLANTIER: I spoke to Chief of Staff Hilton about that. He spoke to the Commissioner about that. I'm not privy to the conversation, but I certainly thought that they were-- I certainly know that they were aware of it. So, you know, I can only say that issue was raised. I can't say, at their level, how they may have thought of it or what they spoke of. Ultimately, they gave me permission to go.

ASSEMBLYMAN MIKULAK: Okay. The December 8 memo from you to Mr. Hilton says, "We have reviewed our proposed changes with both inmate committee and the population as a whole through therapy groups and have met with a generally response." Do you still have a favorable response from the inmates?

MR. PLANTIER: I would say at this point, now that it has started, the response is probably mixed. We are getting complaints from several who have been displaced from a group that they used to be in. They seem to be coming from one particular area at this time.

Again, we're too-- It's too early in the process to fully evaluate what the response is going to be. Am I

overwhelmed with complaints? No. But I think even to say that that's not going to happen, I would say it's too early in the process. I think we have certain things that we have to straighten out in terms of rosters, in terms of getting men in. We have psychologists coming to us all the time saying, "Well, we can do more than we thought," and sometimes less than they thought. So we're really in the process of-- It's flux right now.

SENATOR BASSANO: You're not up and running fully?

MR. PLANTIER: Not running fully, no. We're up and running, I would say, close to 50 percent of what we're going to be up and running--

SENATOR BASSANO: I can tell you that yesterday 11 letters came from your institution and the day before 6, all complaining about the changes.

MR. PLANTIER: Yes. I'm very well aware -- there seem to be a lot of them.

SENATOR BASSANO: We're getting some fan mail.

ASSEMBLYMAN MIKULAK: How many additional treatment refusals--

SENATOR MATHEUSSEN: Excuse me.

SENATOR INVERSO: We have a problem here on this.

Go ahead John.

SENATOR BASSANO: Go ahead, John, I'm sorry.

SENATOR MATHEUSSEN: I'm not so sure that criticisms of the new program, from where the criticisms are coming, are good or bad.

ASSEMBLYMAN MIKULAK: That's not the point, John.

SENATOR MATHEUSSEN: Well, I think it is part of the point though, with all due respect, Mr. Chairman. I think if people are criticizing the program, perhaps it is being effective, and maybe it's not business as usual where everyone had a happy environment.

We go back to the testimony of the first witness in that Avenel is not just a treatment center, but it is an extension of the penal system, and not everybody should be necessarily happy that they are there. They are there for a reason, and if they're getting complaints about it, maybe that says something about the program. I'll wait to be a judge on whether or not it's--

ASSEMBLYMAN MIKULAK: I agree with that.

SENATOR BASSANO: So will I, but I think our complaint up here is that in the middle of this Task Force meeting, trying to look at this issue, that changes were made without even notifying the Task Force.

SENATOR MATHEUSSEN: I don't disagree with that.

SENATOR BASSANO: I just think that is a terrible way to do business.

SENATOR MATHEUSSEN: I don't disagree with that.

ASSEMBLYMAN MIKULAK: My question, which I'm leading up to, is: How many additional treatment refusals have been generated since this change?

MR. PLANTIER: To my knowledge, of what I've seen, none. Not to say that there hasn't, I have not seen any. It remains--

ASSEMBLYMAN MIKULAK: Well, that's not the information I have.

MR. PLANTIER: It remains at 46. Now if that changes-- You know, quite frankly, change is difficult. I think everybody knows that. So, what you have--

ASSEMBLYMAN MIKULAK: It's difficult when it happens in a vacuum, Mr. Plantier. It's difficult when you don't sell the change.

MR. PLANTIER: Assemblyman, I sold the change to my superiors. If they don't--

ASSEMBLYMAN MIKULAK: Well, then your superiors had an obligation to sell it to the Legislature.

MR. PLANTIER: I can't speak for them.

ASSEMBLYMAN MIKULAK: We're at a critical juncture.

ASSEMBLYMAN MALONE: Mr. Chairman, just a couple of questions.

Number one, if you're going to move the target during the process, what we've done up to this point is meaningless. Because you're going to start saying to us, "Well, we have to reevaluate. You're going to have to wait until we reevaluate." Then, we're not looking at the same set of information.

I'll be perfectly honest with you, and I'm only one person on this Task Force, I think maybe the best thing to do is to ask the administration of Avenel to step down and bring in a new administration of Avenel, so we can really take a very close picture and look at this thing.

Because, as far as I'm concerned, if you're going to continue to change the target, no one is ever going to be able to really hone in on this thing. I think this thing is of such critical nature that I think it's important that we have confidence in the people who are running Avenel, that they are being straight with us.

Because, right now, I don't believe you are, and if I came back here a month from now, you may say, "Well, we changed it again. We did this. We talked to the Commissioner." I have really lost total confidence that you're being straight.

MR. PLANTIER: Well, I can't--

ASSEMBLYMAN MALONE: I'm one individual, I don't know how the rest of the Task Force feels.

MR. PLANTIER: I can't answer to that. I can only answer to the fact that, you know, we haven't changed the target. What you're looking at in terms of the effectiveness of treatment at Avenel is still there to look at.

ASSEMBLYMAN MALONE: That's the whole reason for being here, to assess the effectiveness of the treatment at Avenel. If you have changed that process, what are we doing here?

MR. PLANTIER: Well, I never thought-- From the questions that I've received and from the questions I've heard, I never thought you would be getting into the nitty gritty of how a group is run or the other types of issues that we're doing, and frankly, no one on the Committee said to "Hold fast" either and "Don't do anything." We make changes all the time in the institution.

SENATOR BASSANO: Not of this magnitude, though. You knew, and I'm sure Corrections also was aware, from the time we visited Avenel in August with the Senate President, that this Task Force was going to come about to take a look, specifically, at this issue. I find it mind-boggling that in the middle of this Task Force meeting, that changes like this are going to be made.

I think the point that has to be driven home is the point that was just made by the Assemblyman, that no matter what we do, you're going to say, "Well, give us a chance because now we have a new program." I think that is wrong. It's a poor way of doing business.

MR. PLANTIER: No, I'm not saying that at all. I'm certainly not saying for you to-- Everything that you were looking at, you can continue to look at. They're certainly not-- The changes are not that significant that they are going to affect anything that you're trying to do. So that's the only way I can answer that.

MR. MULLER: Senator, if I may?

Some of the things that were brought up in our initial meeting with you -- I think it was in October or November -- were so specific and so easily identifiable that you had more than an ample opportunity to say, "Well, you know, we are looking at that."

For example, the lack of progress notes, the lack of evaluations, appropriate psychiatric or other related evaluations that couldn't be documented, things of that nature,

which, I presume from what you're describing here, would be improved upon by virtue of implementation of this program.

MR. PLANTIER: The lack of progress notes were not brought up when I testified. That was brought up at the second hearing.

MR. MULLER: Oh, you were aware of them then?

MR. PLANTIER: I was aware of them, sure.

MR. MULLER: So don't you think, knowing something as dramatic as that, that we would have gotten some input saying, "Well, we are looking at that?" We got no indication on this Task Force that you were even considering changing absolutely unprofessional behavior.

MR. PLANTIER: Frankly-- Frankly, the issue of progress notes, from what I heard was said, I totally disagree with who said it. I disagree with the statement.

ASSEMBLYMAN MIKULAK: Mr. Plantier--

MR. MULLER: You had the opportunity to provide--

I'm sorry, go ahead.

ASSEMBLYMAN MIKULAK: You said you had permission of Mr. Hilton and Commissioner Fauver. Do you think we should get Commissioner Fauver to a Task Force hearing, Mr. Hilton back to a Task Force meeting, so we could ask them? Because you're saying you're only following orders.

MR. PLANTIER: I'm telling-- I can't speak to what you should do, Assemblyman. I can certainly tell you that was my chain of command. As it exists right now, that is my chain of command, and I did seek and I did receive approval from them. Now, maybe it should have been explained different to me, but this Committee has never been told to me to be my chain of command. If anyone was going to tell you about it, they should have instructed me to tell you about or, I would assume, tell you about it themselves.

SENATOR BASSANO: I think you should have done that voluntarily when you appeared before us, to tell us that you

were making some changes so, at least, we had some idea. That was your responsibility, not the responsibility of the Commissioner. That should have been said to us, "These are some of the things we're talking about doing. I'm working with the front office on doing it, and hopefully, we're going to implement this new program." We had no idea what you were going to do.

ASSEMBLYMAN MIKULAK: I think you did yourself a great disservice by doing that, by acting in that manner.

SENATOR INVERSO: May I ask, Mr. Chairman--

SENATOR BASSANO: Please, Peter.

SENATOR INVERSO: Superintendent, it is clear that you don't report to us in terms of the ongoing functional administrative responsibilities that you have. It is clear. I do think, though, that there is a certain element of political incorrectness here in having the members of the Task Force read about this in the newspaper, in view of the fact that we were at Avenel a few weeks before the implementation of the procedural changes.

I think it's a question of notification. Was it ever discussed with the Commissioner as to whether this Task Force should be notified on or about the same time as the media was notified? I mean, obviously, we were there, our presence was there. I'm trying hard to give you kind of an even approach in dealing with this issue.

But it is clear that this Task Force has been working many hours to try to come to a resolution. We're trying to work with you. I think Chairman Mikulak said the correct thing. You did yourself a disservice. Because it appears as though it was not an attempt necessarily to move the target, and maybe it was that, but clearly, our presence should have been acknowledged, and we should have been informed. I don't know if we would have said, "Don't do it," or if we have the authority to say, "Don't do it." But at least advise us, so we can be forearmed and for

notice that you're going to make these changes. I think there is a breach here of some protocol if not political incorrectness.

ASSEMBLYMAN MIKULAK: The perception is real bad.

MR. PLANTIER: Well, I can only answer what I know. I had no conversations with the Commissioner myself. If I was to guess, I would have assumed that he would have notified the Chairmen of the Committee. But since I had no dialogue with the Commissioner, aside from receiving the written note back, and the only one I spoke to was Chief of Staff Hilton, I'd have no knowledge of what would have happened at that time.

SENATOR INVERSO: We probably should direct a letter to the Commissioner.

MR. PLANTIER: Nor would I have-- Nor did I tell this to the press. This was not something that we tried to leak to the press or give to the press. It was not certainly anything that we really even wanted to talk about. We will be glad to talk to this panel about it.

SENATOR INVERSO: We recognize that your therapy program should be dynamic. It should be ongoing. You should make improvements. We'll determine whether this is an improvement in our own estimation. But, clearly, we're a part of the process.

Whether we have administrative functional control of you is not the issue. The issue is we're part of the process, we're trying to work with you. I have asked questions in past meetings about, what do you need to do a better job at your mission? So it is clear that this is not adversarial. It should have been kind of a dichotomy, work with us. But this happens and it leaves a sour taste in all our mouths. That's not good.

MR. PLANTIER: Well, I can only-- For the staff of the institution, I can only apologize for that. It was not our intention, nor were we trying to move targets. We certainly

weren't trying to do anything to, you know, hurt the Committee in its process to find out about Avenel.

But, you know, again, I agree we are dynamic. I don't think anything that we're doing changes the focus of what you're looking at. You know, it's internal change, and if I had said I threw away half the programs because I found them to be no good, then, yes, I think I would have had something that I really owed you an explanation for. If I told you that we tried to restructure the existing programs so that they would run better, which is what we did, you know, I would have been glad to talk to you about it, but I didn't see it as a--

SENATOR INVERSO: We probably would have said-- I don't know what the reaction of this Task Force would be. Individually, we probably would have said, "So long as you're not committing major resources at a point where this Task Force is trying to reach a decision, do it." Because you've got to keep your program functioning and make it better. It is clear that it is not as good as it needs to be.

But I just wanted to speak out, because I, for one, have tried to look at your situation in terms of: Is the mission being fulfilled? But have you had the ability and the resources to fulfill your mission? You're making changes and that's good. But, clearly, there is a protocol or an etiquette breach here, that once having said it, I guess it should be put aside. But it hasn't helped from an attitudinal standpoint in dealing with this situation.

MR. PLANTIER: I can tell. Okay. I certainly agree with you, and, you know, I'm certainly here to listen to what you have to say about that. But, again, I did not feel it was my role. Again, I can't speak for my superiors, but I did address all this with my superiors, and I wasn't trying to thwart your efforts, that's for darn sure.

SENATOR BASSANO: Continue telling us what changes you've made.

MR. PLANTIER: I think, since we're going to get into the nitty gritty, I'd like to turn it over to Wayne. He can certainly speak to how it is structured now. We are dealing with the same number of staff. We have not hired any additional staff since we last had a meeting; although, we are in the process of hiring three, which will certainly help our numbers.

The bottom line goal is to just be a little more effective with what we do.

SENATOR BASSANO: May I just interrupt you? Senator Matheussen has one fast question.

SENATOR MATHEUSSEN: It's not so much a question, it's a request of the Chairs, and that would be-- I happen to agree with what Senator Inverso had to say, and I think now that it has been said, we should move on.

But I don't know that the Task Force should ignore the fact that we need to have a cooperative effort. Perhaps this Task Force should direct some inquiry or some statement to the Commissioner asking why this happened and ask that it not happen again.

If we're going to work on this together, if we're going to be joint partners in improving either Avenel or how we treat sex offenders in this State, then we should be working together and not on two independent courses. I would hope that we would put Commissioner Fauver on notice of that and ask that he consider that in his future endeavors with regard to Avenel.

SENATOR BASSANO: I will ask OLS to draft a letter for both myself and Assemblyman Mikulak to sign to the Commissioner.

John.

SENATOR GIRGENTI: Lou, I have to say that I sympathize with what you're saying and what the Assemblyman is saying, because the bottom line is that we spent two days there. We took our time and we were sitting in the facility of Avenel, and to not be notified of major changes, I feel like we're wasting our time when we're going about doing this.

If this is going to continue, I can't see us going in any direction. We're just at loggerheads, really, if we're going to continue to shift or change the program. So, if we can get an agreement that we're going to work together and we're going to share together whatever is going on, fine. If not, then I don't know what we're doing. We're on two separate courses here.

We're supposed to be working together in this process. We're not supposed to be the last people to know and be embarrassed by the fact that people are calling us, questioning us about something we don't even know the first thing about, and we spent two days there.

SENATOR BASSANO: Thank you, John.

W A Y N E S A G E R: Thank you. I'd also like to give Dr. Graffin an opportunity to add anything I have, since she has also been involved in the changes at this point.

One thing I think we did touch upon the last time I was speaking before the panel was that current literature suggests that cognitive behavioral forms of therapy appear to work, and from the data we have, appear to work more effectively than other forms of treatment.

What we tried to do with this change was respond to that information that we have in the field right now. Now, the specific changes are as follows:

* We're going to expand our orientation group that we have at ADTC.

* We're going to expand the prerelease group.

* The victim empathy group is going to stay more or less the same, but we're going to offer it more often since we find that a group that is very valuable, and that we want to make sure that the people get before they leave Avenel.

* We're going to offer a personal victimization group, which often is necessary to give before you give a victim empathy group, and that was something that we had not given before.

* The social skills training group will be about the same as it was before.

* The relapse prevention group will be run more often. Again, another group that is found to be very effective, and we want to make sure that everybody gets that relapse prevention experience before they leave the institution.

* The anger management group will stay about the same.

* The sex education group will run more often, and the sexual reconditioning, which we did on an individual basis, will be done in a group setting from now on.

* Substance abuse groups will continue to run, and we will make every effort to have them continue to run as they have before.

* The process groups are the general types of therapy groups that have always been a staple of Avenel throughout the years. What we plan to do with that is to have those continue to run, as necessary.

In other words, we won't put people in a primary therapy group automatically. We will have them assessed in an orientation group and determine if an ongoing process group is necessary, or if we should put them in the cognitive behavioral groups -- which, as I mentioned before, have been found to be very effective -- maybe a process group down the line, maybe a process group for a while, and then not a process group for a while.

These groups will run in a four-month turnover segment. At the end of every four months, we intend to evaluate each individual and evaluate each group. What we hope that gives us is an ability to have an ongoing evaluation of the program so that we can add more programs, subtract programs, have more process groups, more substance abuse groups, as the opportunity presents itself, as we feel like we need to do.

What we think will improve by making this change is an ongoing evaluation, an evaluation of the program on a regular basis that's actually written into the program, so that we can constantly look at ourselves, and be critical of ourselves, and add things, and subtract things as we feel is necessary.

One of the problems, I think, that we have in not spelling these things out in details the last time was just about everything that I mentioned to you was in process the last time. We were running each of these therapy groups the last time.

What we're changing is the way we assign inmates to each therapy group and the way we assign therapists to inmates. The only other major change that we're going to make -- and I think part of this is in response to your inquiries the last time you were here -- is that we intend to assign the therapists by housing wing.

What we hope that will do is allow the therapist to be out on that housing wing more often, have an ability to take a look and see what is going on on the housing wing, have an ability to deal therapeutically with what is going on day in and day out on that housing wing.

The other thing that it will allow us to do is to get more therapy out of the same amount of resources. Because if we're running therapy groups with men in the area that they're living in, it gives them an opportunity to meet with each other not only during the therapy sessions, but any time during the day and discuss therapy issues.

SENATOR BASSANO: Didn't you tell staff that their caseload would be preserved? It is my understanding that you had told them that. Now, you're telling us that you're going to shift things around?

MR. SAGER: Well, I don't think we told people that their therapy group was going to be preserved. In one of the meetings that we had--

SENATOR BASSANO: No, no. Didn't you tell staff that their caseload would be preserved, that the people that they're serving would continue?

MR. SAGER: No, we didn't. What we told them was that because we're going to move to wing-based assignment that there would be switches, and people would be able to give us a list of people that they felt it would be okay to switch to another therapist and then another list of people that they wished to keep for therapeutic reasons.

What we did after that was meet with each psychologist and try to reach a determination of the number of people who each psychologist felt comfortable with transferring and comfortable with keeping.

ASSEMBLYMAN MIKULAK: At this stage, how many inmates have yet to be assigned under this new structure?

MR. SAGER: I'm going to let Dr. Graffin answer that because she is responsible for the nuts and bolts of the assignment.

N A N C Y W. G R A F F I N, Ph.D.: When we made the changes, we had to take information from the therapists and make the assignments for the inmates based on the feedback from those therapists. We have over 700 inmates, and I'm sure that you can understand doing all that by hand mistakes were made.

What we did was we gave the therapists the proposed group rosters, which we had made based on the feedback they had given us, asked them to review it, and then put in writing whatever men may have been incorrectly assigned or not assigned at all, and then we would correct those errors. We received feedback from all but one of the therapists about that. So all men should have been assigned properly, assuming that the therapists did what they were asked to do which was to--

ASSEMBLYMAN MIKULAK: At least the primary?

DR. GRAFFIN: They were either assigned to a process group or a module and some to both. We also-- Some of the

therapists expressed concern that they had inmates who had been very motivated for therapy, and those inmates wanted to be involved in more than one group at a time. That is the ultimate goal, but again, given the amount of information that we're trying to manage, we just, for the initial time around, tried to get one assignment per inmate.

We asked therapists if there was someone who really needed to be in more than one group during this cycle, that they also put that feedback in writing, and that to the best of our ability, we would accommodate those requests as well.

ASSEMBLYMAN MIKULAK: Okay. The number I got from a staff member who shall remain anonymous is, to date, there are 250 inmates who have yet to be assigned any type of therapy.

SENATOR BASSANO: I have 270 as of the 30th.

ASSEMBLYMAN MIKULAK: We're hearing things. We have our own--

DR. GRAFFIN: I'm not sure where that information is coming from. Every request that I've gotten from therapists saying that they had reviewed their old caseload and had double-checked to make sure the men were assigned to groups, those mistakes were corrected.

SENATOR BASSANO: Are you getting refusals from prisoners now saying that they don't want therapy because they don't want to change therapists?

DR. GRAFFIN: I've had one or two write, saying that if they weren't able to continue with a particular therapist they had been involved with, they wouldn't continue.

SENATOR BASSANO: That is not what I'm getting from some of the letters we're receiving.

SENATOR MATHEUSSEN: That's one less person you have in Avenel then. That's the way I look at it.

SENATOR INVERSO: Get them out of there, if you can.

ASSEMBLYMAN MIKULAK: We have to modify the laws to do that.

SENATOR MATHEUSSEN: Absolutely. That's an easy one. If they don't like their therapist--

SENATOR INVERSO: The message better go out loud and clear to these guys, "It's not tolerable."

SENATOR MATHEUSSEN: I don't like my dentist either, but I still have to go to him.

MR. SAGER: There are a few more points that I would like to make regarding the change and regarding our input with the therapy staff as far as the change goes.

This initiative was a treatment staff initiative. It wasn't an administrative initiative. The treatment staff felt like they would like to change the program in certain ways. Everything that we've done with this has been by consensus of the treatment staff. There are members of the treatment staff who are very unhappy with these changes. But what we attempted to do was to go with the majority of the treatment staff, and to take their professional opinions, and to go with them.

Now, what we did in terms of the change was we would have a subcommittee meeting where we would attempt to work out changes, then we would have a meeting of the full treatment staff, then we would have a subcommittee meeting, then another meeting of the full treatment staff. I think we did everything we could in terms of trying to communicate what the proposed changes were and to get feedback from the entire treatment staff.

So I take issue with the fact that this was foisted upon the treatment staff. It was the treatment staff's decision that certain members of the treatment staff weren't comfortable with is the way--

SENATOR BASSANO: Is this a model that you're following from some other part of the country?

ASSEMBLYMAN MIKULAK: Minnesota?

DR. GRAFFIN: Yes.

MR. PLANTIER: Minnesota and Vermont are two places that came to mind. The NIC consultant that came out in May was the one that had run the Minnesota treatment program, and she, certainly, thought of better use of some of the staff to pattern some of our programs after that. It is also very reflective of the treatment program that exists in Vermont right now. Yes, it's pretty much a known model.

DR. GRAFFIN: We have a somewhat unique position because the size of ADTC is larger than just about any other institution that's given the mandate of treating sex offenders. Also, most other programs have an outpatient component which, as you well know, is very limited because of men maxing out and not participating voluntarily in our aftercare program.

So, what we've tried to do is, we've tried to look at the research and look at how other programs are structured and to use what clinically seems like it would also work for our population. But then also, again, using our clinical judgement to add on some things that we think would work for our specific population. Some of that is based on traditional inpatient treatment, which is an emphasis on what's called milieu therapy, which is what Mr. Sager referred to before.

SENATOR BASSANO: Simple question: How many hours of therapy will someone look at receiving under the new program if they're in Avenel?

MR. SAGER: I looked at the numbers just yesterday, because I thought I might get that question. So what I came up with was this. We're going to hire three new psychologists. We have approval to hire three new psychologists. We also have the ability to use our social workers more in the therapeutic process.

So, as the changes are occurring right now, we've had 69 therapy, professionally run, groups per week before the change occurred. Actually, we had 150 groups per week all together.

I want to point that out because we often hear one and a half hours a week per inmate for therapy. That's for the inmate that would take one therapy group and does not, will not, go to any other therapy groups.

We've always had, always since I've been here in 1981-- We've always had the opportunity for these men to participate in many more than one and a half hours of therapy per group. If a man chooses to go just to his primary therapy group and no other therapy group, he'll go one and a half hours per week. So I think that's something that needs to be said.

We actually, before the break, ran 150 groups a week. We don't have any other room to run more than 150 groups a week. That's an enormous undertaking to begin with, and we're doing all we can in terms of the quantity of groups up to this point.

ASSEMBLYMAN MIKULAK: The first time we talked in November, you were in charge of therapy.

MR. SAGER: Yes.

ASSEMBLYMAN MIKULAK: Now, you are an administrator or off to the side? There is a new-- This lady-- Someone was brought in to be the head of therapy now, to run the therapy? You're all changed. Can you explain that? That's what we don't--

MR. SAGER: I think maybe Mr. Plantier--

MR. PLANTIER: I'd be glad to explain it for you, Assemblyman.

Dr. Graffin was hired during the summer specifically with the role in the future to take over the Psychology Program as the Director. We haven't made that change yet. It's been a slow transition period. Mr. Sager and I and we feel it would be best better served at this point if he were doing administrative duties, and that's where he'd like to go with his career at this point. So Dr. Graffin is in the process of learning the Psychology Department, learning the staff and is being groomed into that role with our full intention of doing that.

ASSEMBLYMAN MIKULAK: Assemblywoman.

ASSEMBLYWOMAN WRIGHT: Mr. Chairman, just a brief question about credentials because I was not on the Task Force for your first hearings.

I don't know your credentials or anything. I assume your resumes or CVs are on file, but could you just tell me what your expertise is that brought you to this position?

MR. PLANTIER: I have a bachelor degree in psychology. I've been with the program since 1973, first at Rahway State Prison, at Menlo Park Diagnostic Center, where I worked with Dr. Riscalla. I was not a teacher there, as she said, I was an assistant social work supervisor, and I ran the Outpatient Services Department, the Diagnostic Department.

I've been with the Adult Diagnostic and Treatment Center since it opened in September 1975, and we took inmates in February 1976.

ASSEMBLYWOMAN WRIGHT: Are you licensed to treat?

MR. PLANTIER: I'm not a psychologist.

ASSEMBLYWOMAN WRIGHT: So you would do administration?

MR. PLANTIER: I do administrative duties.

SENATOR BASSANO: Your background is basically in penal institutions?

MR. PLANTIER: I do administrative-- No, basically, I've done social work for the program for most of the years I was there and then administrative work.

ASSEMBLYWOMAN WRIGHT: My point is that this is not a clinician, someone who is treating people. You are making policy decisions. I'm going to Dr. Riscalla's point earlier of who is practicing medicine, psychology, and social work, and what their credentials are. That was my point in asking. I think you're telling me that-- I don't know what point. Some of the law has changed over the years as to who can practice what, but, currently--

MR. PLANTIER: I've never been a clinician there.

ASSEMBLYWOMAN: Okay, that was my question.

Dr. Graffin?

DR. GRAFFIN: I'm a doctoral psychologist. I've been with the ADTC since November 28, 1994. I am a clinician. I haven't provided any therapy at the ADTC to date because of the changes that have been in place, but I will be doing that.

ASSEMBLYWOMAN WRIGHT: Did you practice prior to coming here?

DR. GRAFFIN: Yes. I worked primarily, actually, with survivors of sexual abuse for several years, also somewhat with sex offenders, but the emphasis has been more with survivors.

I'm in the process of being licensed. The final step in getting licensed in New Jersey is an oral exam. I've submitted my written case example six months ago and am waiting to be scheduled for the oral.

ASSEMBLYWOMAN WRIGHT: At some point I want to hear more about -- at least for our records-- To be sure whether it was before you came or now that you've changed, I'm interested in the credentials of the people who are practicing under you. I assume that they all work under you now?

DR. GRAFFIN: I'm not sure that I'll be supervising them clinically, but I will be Director of Psychology and those people will be--

SENATOR BASSANO: Are you Civil Service?

DR. GRAFFIN: I'm a provisional Civil Service employee.

ASSEMBLYWOMAN WRIGHT: Well, I guess the first question is: We would be able to learn from you the credentials of all of those people who are treating people?

DR. GRAFFIN: Yes, I suppose.

ASSEMBLYWOMAN WRIGHT: That is something that you will also be looking at, I assume?

DR. GRAFFIN: Yes.

ASSEMBLYWOMAN WRIGHT: The question is--

ASSEMBLYMAN MALONE: Who is supervising your staff clinically right now if you're not licensed to do so?

DR. GRAFFIN: Okay. The supervision setup right now is that a licensed, doctoral level psychologist provides supervision, and then there are, I believe, four supervisors that he supervises directly. Two of them, I think, are licensed psychologists, and then they supervise the rest of the staff. So there is a hierarchy, with the person who has the highest level of qualifications providing supervision for the next level.

ASSEMBLYMAN MALONE: The financing of the changes that you've done, is there some additional cost that is going to be, or is it something internal?

MR. PLANTIER: No. No, it's just internal. There is no additional cost. I mean, we had, at our initial hearing, requested of this Committee a wish list of what we would hope we would need to enhance the treatment program and provide better treatment. That's still all pending. As a result of those initial hearings, the Commissioner gave us approval to hire into three vacant psychology positions, and we are in the hiring process for those three additional clinicians at this time. One is scheduled to come on board in mid-February. A second is in his credential review period, and a third we're in the interview process for.

ASSEMBLYMAN MALONE: But I guess in the testimony that we had gotten earlier, the first time we were here, it was obvious to all of you on staff here that you knew you had to do things better, and that you were trying to improve the situation here as far as your therapy and the things that you were doing.

MR. PLANTIER: I think the most-- The fairest answer I can give you to that is, yes. Yes, we certainly did. We were certainly very, very unhappy with the cutbacks we experienced in 1992 with our psychology staff. We were certainly very unhappy with the caseloads and how they had skyrocketed for the

psychology staff. We were very concerned about burnout with the existing staff. So, prior to this whole formation of this Task Force, we had been petitioning the Department for additional staff in those areas.

When you were formed and asked to evaluate us, one of the things that I did initially very early on was write up a wish list of what we felt we needed to better do our job. That was presented to you right at the very beginning, and that still exists so-- Just because we've been allowed to fill some vacancies in the psychology staff, doesn't mean that that wish list has been satisfied by any means.

ASSEMBLYMAN MALONE: I guess I'm not worrying about the wish list. If you were able to do it internally without any additional funds, and you've known for a period of time that you had to make improvements, why weren't these improvements instituted a year ago, a year and a half ago, two years ago?

MR. PLANTIER: Because we just got the report back.

ASSEMBLYMAN MALONE: Pardon?

MR. PLANTIER: We had just gotten the report back in December. That's when it happened.

ASSEMBLYWOMAN WRIGHT: Just one other-- I wanted to stay with the credentials. I don't know Mr. Sager.

You have been supervising, according to the first testimony, the program?

MR. SAGER: I was-- I have been the Administrative Supervisor of the Psychology Department since June 1993.

ASSEMBLYWOMAN WRIGHT: I'm interested in your credentials.

MR. SAGER: My credentials are, I'm a master's level psychologist with a full year clinical internship. I've worked as a psychologist at Avenel, at the Middlesex County Jail, and in various consulting types of situations since 1978. I've published in the-- I've published one article and two general readership articles.

ASSEMBLYWOMAN WRIGHT: But you are a clinician then as well.

MR. SAGER: Yes, I am.

ASSEMBLYMAN MIKULAK: Mayor.

SENATOR McGREEVEY: Thank you, Assemblyman Mikulak.

Who made the decision regarding cognitive behavioral approach, to switch?

MR. SAGER: Well, we've been doing it all along. I think we've talked about the ancillary therapy groups that we've had for, I guess, probably for as long as Avenel has been in existence. So those ancillary groups tried to address the cognitive behavioral type of treatment that's been done in the field all along.

SENATOR McGREEVEY: But who, what person, made the decision to improve or to enhance the cognitive behavioral approach as opposed to client centered?

MR. SAGER: In other words, the most recent changes that focus more on the cognitive behavioral therapy?

SENATOR McGREEVEY: Yes.

MR. SAGER: That was done after Dr. Nancy Steele was in our institution as a consultant, and it was done probably a combination of discussion between the treatment staff and the administration that we would form committees, which would in turn make suggestions that would come back to the treatment staff.

SENATOR McGREEVEY: But, ultimately, Dr. Steele makes the decision? Was this approved by the Commissioner?

MR. SAGER: I believe the overall change was approved by the Commissioner after Mr. Plantier sent that memo in December.

SENATOR McGREEVEY: Mr. Plantier, we've heard some disconcerting testimony here today regarding the appropriateness of the ADTC. I was just wondering-- Two specific points: One, the recidivism rate has previously been discussed, testimony has

been presented, and there is substantial disagreement between the DOC figures and figures that we have received from other groups. My concern is, what do you consider a measurement which is acceptable to determine whether ADTC is working?

MR. PLANTIER: Well, I would certainly think that a recidivism rate, and a good recidivism study would be a good measurement. There are all sorts of things you can study.

SENATOR McGREEVEY: Just for the record, again, the recidivism rate within ADTC is?

MR. PLANTIER: The study that we had, the most recent study -- which was the '84 to '87, I believe, study -- was 18 percent.

SENATOR McGREEVEY: Which is substantially lower than what has been projected by other experts.

ASSEMBLYMAN MIKULAK: It was a short period, I think, when you--

MR. PLANTIER: I haven't seen those figures.

DR. GRAFFIN: Yes, it is, substantially.

SENATOR McGREEVEY: Yes, substantially lower, which either impugns the integrity of the figures or suggests that the methodology by which the recidivism rate was calculated is not the norm.

MR. SAGER: I think we would have to see that study, because I did a--

SENATOR McGREEVEY: I have never seen, and I've taken the time-- I have never seen either a national or a State study that even closely approaches the 18 percent numbers.

ASSEMBLYMAN MIKULAK: It's a short period of time. The longer it goes the higher it gets.

ASSEMBLYWOMAN WRIGHT: No, not necessarily. It's an average.

DR. GRAFFIN: But it's not unusual for numbers in the low 20 percentages to be the outcomes for that kind of period of time.

ASSEMBLYMAN MIKULAK: Yes, 25 to 40 percent.

SENATOR McGREEVEY: Yes, 25, exactly.

MR. SAGER: And that's jails which have treatment programs or jails that do not have treatment programs?

SENATOR McGREEVEY: It goes to the heart of my-- The question is that when we talked before about an hour and a half of treatment time, I mean, an hour and a half, is that all that is essentially required?

MR. SAGER: I think we probably addressed it when you weren't in the room. I'd be happy--

SENATOR McGREEVEY: No, I heard--

MR. SAGER: The hour and a half is not enough. Under no circumstances do we recommend--

SENATOR McGREEVEY: I'm not asking whether or not it is enough; clearly, it is not enough. But there are instances of individuals at the Center who are only receiving an hour and half, is that true or false?

MR. SAGER: That's right.

SENATOR McGREEVEY: Now, how many individuals are only receiving an hour and a half?

MR. SAGER: I don't have that information.

SENATOR McGREEVEY: What percentage?

MR. SAGER: I don't have that information.

SENATOR McGREEVEY: Approximately, what percentage? You know better than I do.

MR. SAGER: Thirty percent.

SENATOR McGREEVEY: So 30 percent of the people are receiving an hour and a half of therapy on a weekly basis?

MR. SAGER: A problem that we have and that we will continue--

SENATOR McGREEVEY: Doesn't that strike you as absurd? These are convicted felons who committed heinous acts for which they're receiving an hour and half, and that's a third of the population?

MR. SAGER: Can I respond to that?

SENATOR McGREEVEY: Yes, it would be fascinating.

MR. SAGER: Yes, it is absurd, but no one knows how to motivate somebody who is not originally motivated.

SENATOR McGREEVEY: Then why-- How long-- God forbid, all the atrocities and all the horrors, and if this Task Force was not established, how much longer would you have continued providing only an hour and half of therapy for 30 percent of the population and not attempt to redress the problem? I mean, simply put, you are releasing individuals who have -- at least a third of them -- only received an hour and half. You're telling me this is absurd. Well, is there a game plan for improving this?

MR. SAGER: Can I answer that question?

SENATOR BASSANO: May I comment before you?

I don't think you can force an inmate, right now, to take therapy, first of all. I think we will force them when the Task Force's report comes out. I think there are ways of doing that. One of the notes that I just handed to Anne was that we should establish some type of minimum in hours of therapy that an inmate has to take at Avenel in order to stay there.

I think that your anger is justified. I don't necessarily know it's justified against--

SENATOR McGREEVEY: Senator, the reason, and I respect your position-- The point being is that I understand these are administrators, and they attempt to follow their charts.

What is profoundly disconcerting is that there is not either the awareness or the wherewithal that in administrating a function which is ostensibly to rehabilitate a particular subgroup of individuals, mindful of how the therapy is so limited, that someone at some point in time would wake up and say, "We're not addressing the problem." Recognizing the statutory limitations regarding the limitation of -- the inability of the State or the Center to impose treatment -- that

someone would wake up and say, "This isn't working because of the amount of therapy time provided, as well as the inability of the Center to coerce such therapy."

It's somewhat incredulous that we've been doing business this way for so long and someone hasn't come to me to recognize-- I don't mean to (indiscernible), but there needs to be an awareness that we ought to be doing this better. I'm not a rocket scientist, but an hour and a half on a weekly basis for a third of the population doesn't measure up. Clearly, the citizens, the bench, the judiciary would think this is a grossly inappropriate measure of treatment.

MR. PLANTIER: Well, Senator, if I may? You know, we have a track record of requesting additional staff to run more programs. We were cut back in the cutbacks that have happened in State government--

SENATOR McGREEVEY: That's a fair, legitimate--

MR. PLANTIER: --and we have requested those staff back.

SENATOR McGREEVEY: That's legitimate.

ASSEMBLYMAN MIKULAK: That is within the Department of Correction, because their budgets are approved every year. The budgets haven't been cut overall. Your budget might have been slowed, but that is within your own battles with your own Commissioner.

MR. PLANTIER: I have no way to go outside of that. That's my mechanism.

ASSEMBLYMAN MIKULAK: Right.

SENATOR BASSANO: If I can say something to Senator McGreevey?

I think the point that you made is extremely valid. That is why, maybe, what this Task Force is going to have to recommend is a permanent Commission to take a look at what is happening at Avenel so that it is on a continual basis. Because I don't think that we could get down legislatively to the point

where we're going to be specific in the number of hours that a particular prisoner--

SENATOR McGREEVEY: Nor should we.

SENATOR BASSANO: Nor should we, but a Commission may be able to do some things of that type.

SENATOR McGREEVEY: I just have one last question and I don't mean to just-- My frustration is just in recognizing I'm not even a novice, let alone an expert, as some of the people that we have heard in terms of treatment.

The last question I have is regarding-- We've heard throughout the testimony that there are various points, checkpoints, if you will, where the inmate is reviewed, particularly, the initial point of diagnosis and, subsequently, the decision to release.

One of the concerns I have is that I believe that there ought to be a punitive aspect to sentencing, clearly to address the psychological, the psychiatric flaws within the inmate's psyche, whatever, but there needs to be a punitive aspect within the sentencing.

When the Center makes a threshold determination as to the "viability or appropriateness" that the inmate has addressed certain basic psychological/psychiatric flaws, what then happens in terms of DOC?

MR. PLANTIER: I'm not sure I understand completely, Senator.

SENATOR McGREEVEY: Once you make a--

MR. PLANTIER: You mean the outpatient -- psychological outpatient -- diagnostic that is done?

SENATOR McGREEVEY: Yes.

MR. PLANTIER: What happens then is the case would go back to the court for sentencing purposes. The judge at that time may accept our decision to place the man, under the Act, and sentence him to Avenel. He may choose, although we find him to be under the purview of the Sex Offender Act, not to place

him at Avenel and place him in State prison. He may place him on probation.

SENATOR McGREEVEY: But after someone, after the judge, after the initial diagnosis, and the judge places him at Avenel -- and for arguments sake, that is an appropriate setting and the inmate spends time at Avenel ostensibly being treated -- at the end of that treatment, when a decision is being made by the Center that the individual has done whatever he ought to be doing, and has achieved whatever he ought to be achieving, what then happens at that time?

MR. PLANTIER: It would be initiated by the actual treating case manager or psychologist, the primary therapist involved. He would then be brought up to staff. The purpose of that staffing would be for that clinicians' peers, a group of psychologists, to make a decision whether they feel the man is ready to return to the community. If they, in fact, vote to refer him positive on that case, he would then receive a parole plan done by the Bureau of Parole, which would be where he would be living and where he would going.

SENATOR McGREEVEY: I guess the question is, and I apologize. I'm familiar with the discharge plan. Is there ever an incidence where the Center says the individual has remedied whatever, but that the individual ought to be transferred to the prison, to Rahway, for example, or to Trenton, to serve a punitive aspect of the sentence?

MR. PLANTIER: Unless there was sentencing that would give him a consecutive sentence to State prison, the Parole Board, since 1980, I believe, has not allowed for cell paroles, which would be what you're talking about. We have no-- We would have no ability to say, "He's done all he can therapeutically here. Now, we want to put him in State prison for punitive time," which I think is what you're asking me.

SENATOR McGREEVEY: Yes.

MR. PLANTIER: Frankly, we wouldn't want to do it that way anyway. If anything, if there was going to be punitive time served, we would like it served on the front end and then take him in for a course of treatment. Because we're treating to release to the community, we're obviously not treating to release to Rahway State Prison or wherever.

SENATOR McGREEVEY: The problem becomes, though, the inherent difficulty with that, because what is one going to serve X, Y, Zed length of time and then say, "Well, we have six months left in the sentence, let's put him in Avenel. I know we can slap him into shape within that period of time."

MR. PLANTIER: I agree with the difficulty of the version that you're describing. Yes, that is going to be difficult, just who makes the decision.

SENATOR McGREEVEY: So I guess what I'm trying to drive at is that there is an ultimate decision. Is there ever an instance where Avenel recommends that a punitive aspect of the sentence be set forth to be performed?

MR. PLANTIER: No, because we can't. Senator, we're not allowed to get involved in the sentencing process.

SENATOR McGREEVEY: But there is nothing statutorily that prohibits DOC, and you are a part of DOC, from saying that an individual either at the upper end of the scale, or at the back end of the process ought to serve punitive time?

MR. PLANTIER: If he is sentenced to Avenel, and the time is strictly--

SENATOR McGREEVEY: No. I don't mean to be overly technical. He's not sentenced to Avenel--

ASSEMBLYWOMAN WRIGHT: Yes, he is.

SENATOR McGREEVEY: But the problem is-- As I understand, Barbara, what happens is the judge makes a decision as to the appropriateness of the Treatment Center--

ASSEMBLYMAN MIKULAK: Classified as a repetitive.

SENATOR McGREEVEY: Classified as a repetitive offender, but is there anything that forbids the Department, once an individual has served at Avenel, from being placed in a jail site?

MR. PLANTIER: We have a mechanism. It's in 10A. It's in our Administrative Code for the Department of Corrections. It allows for administrative transfer out of the ADTC for certain specific reasons.

That would be, number one: If the man is disruptive, cannot be treated, because he is so disruptive he can't function in the Center; he breaks group confidentiality; in other words, he is violating the confidentiality of the therapy group all over.

So there are specifically laid out reasons, whereby, we can administratively transfer them; however, when we transfer him, all conditions of the Sex Offender Act are off.

SENATOR BASSANO: You can't transfer him--

ASSEMBLYMAN MIKULAK: No, we have to do that.

SENATOR McGREEVEY: Just a last question, Senator, and I thank you for your indulgence.

So, basically, what happens is upon the judge making a determination subsequent to your recommendations, one or two options exist. Either A, if an inmate is put into a State penitentiary, indeed, the punitive aspect is served -- I believe in the interest of the State -- or, B, an individual is sent to Avenel where he ostensibly undergoes therapy, against which -- once you have certified him as appropriate for reentry, he is released, never to serve, if you will, a punitive aspect of the sentence.

MR. PLANTIER: Well, they consider-- They consider the Avenel sentence, the mandatory minimums that are routinely imposed on our cases, to be considered-- Legally, they are considered the punitive aspect of that sentence. That was State v Chapman of some years ago.

So the State has never differentiated between punitive aspects of sentences, whether they're served in Avenel or whether they're served in another State prison. If a mandatory minimum is imposed, as it is in many of our cases, that is considered the punitive aspect of their sentence; although they serve it at Avenel.

The problem that you're raising, that I think is a very difficult one, is where do you say that that punitive aspect has been served and now it's treatment? Now, we have to worry about getting this guy rehabilitated. If he's in another State prison, where do we draw the line and say, "Well, we need three years for treatment," as opposed to, "We need four years for treatment?"

Frankly, I don't think the state of the art in psychology and psychiatry is that good that you're going to be able to make that kind of a determination. You may be able to determination some level of motivation, some level of intellect, but I don't think you can clearly make a clear determination of, "Well, it's going to be three years and that's what we need." Because in many, many cases it may be much more, and in very few cases it may be a little less. So that's a hard one and I agree with you. It is a very hard one to figure out. It's going to be a big struggle if that's the way you're going to go.

SENATOR McGREEVEY: Thank you. Thank you for your time.

MR. SAGER: Could I make one statement in response to the once a week, the hour and a half therapy, the 30 percent or so people who do get that.

I'd just like to make a statement, because if we leave it at this, it might seem that we were a little bit secretive, that this was something that went on that we didn't want other people to know about.

I just wanted to say that I'm responsible for the presentations, for the outside presentations that Avenel gives.

We give presentations to people on the outside. We give, I guess, probably about two a month, over the time that I was in charge of this type of thing. We have brought this type of thing up every chance we could.

I mean, we have to deal with these men day in and day out. We know what they're capable of. We know what the problems could be. We absolutely would not feel comfortable not presenting this to the people who came and listened to us--

SENATOR McGREEVEY: There is enough blame for everyone. But the important thing is, as you note, that the problem be remedied as Senator Bassano set forth.

MR. SAGER: I just wanted to let the Commission know that the therapists at Avenel have attempted to do what they could to let this problem be known, and I didn't want to let that go.

SENATOR McGREEVEY: Thank you.

DR. GRAFFIN: I just wanted to make a comment in terms of numbers. You were talking about an hour and a half of therapy for some inmates. If you were to set your goal as three hours of therapy a week -- that's two groups -- and you use what we're now trying to implement, which is a cotherapy model, so that there are two therapists for each group -- part of that is to help address the issue of burnout, because it is a difficult job, it's a difficult population--

SENATOR BASSANO: No, we want to give you the authority to say how many hours are necessary and what classes have to be attended, and if you don't attend, you're out of the institution.

DR. GRAFFIN: I just want to say this as an example, though. If you do that, if you have two groups per inmate -- and we have about 700 who are participating in treatment right now -- if you set caseloads for the therapists at 8 groups a week, which is pretty much the maximum, we would need 23 therapists working full-time with this population to be able to

provide that. I think it's helpful just to have the resource numbers--

MR. MULLER: Not really. That's not accurate, Senator.

ASSEMBLYMAN MIKULAK: You're also assuming that the population remains at 700. Now, suppose a third, who have excessive sentences, serve some of their time elsewhere. Then you have the two-thirds you could deal with on a--

MR. SAGER: Or not only excessive sentences, but people who aren't willing to do therapy.

ASSEMBLYMAN MIKULAK: Correct, and we're looking at them real hard. That's what you need the Legislature to--

SENATOR BASSANO: We're looking at downsizing the number of people that you have, so that the people who are there are getting the help.

I have a list of people who want to ask questions, starting with Senator Matheussen.

SENATOR MATHEUSSEN: Thank you, Mr. Chairman.

One thing that Senator McGreevey brought up, and I think is interesting, and that is going back, I guess, to the original calling of Avenel. Perhaps I'm confused--

One thing we do know is that Avenel was created to somewhat segregate the population of sex offenders from the general population for their own safety, as well as the creation of Avenel for its diagnostic and treatment purposes.

Is it possible that the setting at Avenel could also be -- and I'm not suggesting that you're running some place that is nice. I visited the Center. I was not one who wanted to stay an excessive period of time. I didn't like walking, quite frankly, but I did it. It's part of my responsibility. I didn't find it to be a nice place to spend a great deal of time. Is there something lacking at Avenel that somehow removes the cloak of being a punitive center, as well as being a treatment center? If so, how can we correct that?

Because what Senator McGreevey brings up is: Well, if we have punitive to spend, it shouldn't be spent at Avenel, it should be spent some place else. Can we combine those things?

MR. PLANTIER: I had a point that was raised earlier by Dr. Riscalla that I think you're touching on exactly. One of the problems at Avenel, and frankly, ladies and gentlemen, it's not just a problem at Avenel, if you go into any State prison today, you're going to find people laying around. You're going to find a lack of work programs. You're going to find a lack of vocational training programs. This problem is not inherent to Avenel.

But I would agree with a lot of the statements that I've heard, and that is good work keeps them busy, it may teach them a second skill, helps them, helps the institution. One of the things that we don't have at Avenel are any good work programs. We make work wherever we can. We just find menial jobs -- clean this, clean that, you clean that bar, I'll clean this bar -- just to keep those guys having some semblance of a job.

When you walk in there-- I'll be honest with you, I go through with the groups and I say, "Yes, they're all assigned a job," and quite technically I'm right. They are all assigned a job. But their job might be for a half an hour, their job might be for an hour.

I have probably no more than 10 percent of that population that's putting in even a half a day's work. The good jobs, the ones that require, let's say, six or seven hours to complete, there is such a waiting list for those jobs that these guys are going to wait years to get into them.

So there is too much idle time. There is too much sitting on their bunks. It's not because we don't want to do something with them, it just because we have no damn thing to do with them.

SENATOR MATHEUSSEN: We need to address that, and this Task Force is here to help address that. I think that is one of the things, that is one of the mandates that we must address. Because every single one of us that walked out of that Center that day basically said the same thing. We all, perhaps, used it in a different way, but we all said the same thing and that was, "Boy, I saw an awful lot of people laying around doing nothing." That was one of my first reactions. You and I discussed this one-to-one while we were walking through the Center, and I remember it distinctly.

So there is something that we need to do to, perhaps, increase the punitive nature, as well as the therapeutic and diagnostic nature of Avenel. I would hope that the Task Force address that.

The other thing you gave me an opportunity. You opened a door a crack, and I think I'm going to help you open it a little bit more -- maybe, maybe not. You talked about the ability to transfer -- and I joked before about "even I have to go to my dentist," and, by the way, he's my personal friend and I still don't like going to him -- we talked about the therapist and the fact that the inmate doesn't want to visit that particular therapist, and we say, "Oh well, what can we do?"

Under the Code, Section 10, as it is presented now under the Code, specifically, if you could, outline how you go about to administratively remove them from Avenel and put them back in the general population.

MR. PLANTIER: It would be a very simple process. The psychologist who is the primary psychologist, the case manager, would write a report to our classification committee recommending that individual for transfer from the ADTC based upon a specific issue as outlined in 10A. Okay?

SENATOR MATHEUSSEN: Does 10A give you, and I haven't reviewed 10A, because you just--

MR. PLANTIER: Yes, 10A gives you basically three areas in which you can administratively transfer.

SENATOR MATHEUSSEN: Is refusing treatment by a specific counselor--

MR. PLANTIER: Refusing treatment over a one-year period of time would be.

SENATOR MATHEUSSEN: You have to go one year?

MR. PLANTIER: Yes. Basically the reason for that being that they don't want to just transfer people quickly, because some people may take a year to come around and begin therapy. So that was the basis for making you wait that long. But, yes, for the lack of doing therapy, for failure of doing therapy is one of the reasons.

That Classification Committee would then write down to a Special Classification Committee, which is comprised of Deputy Directors and an Assistant Commissioner down at our central office, who would make the final determination based on that report.

If the man was transferred by the SCC to another penal facility, all conditions of the Sex Offender Act would come out from under him, and he would be subject to the parole regulations of any other State prisoner.

The problem that happened with this, and it happened-- Hopefully, it can be straightened out, but we did do this at one time -- as a matter of fact, we did it at one time several years ago to alleviate overcrowding and get rid of the therapy refusals. We transferred out some 20 individuals in the course of like one day. They were all our therapy refusals. They all said, "Hallelujah, let me out of here." Most of those people went to State prison. They had regular parole conditions imposed upon them. They were all mostly eligible because they had done some period of time, and they had wonderful adjustment records. The Parole Board basically paroled them all.

So what I had was, after a period of weeks of these people going and friends writing friends into the institution saying, "Wham, I'm on the streets already," I had another 24 therapy refusals all waiting to say, "Transfer me next, transfer me next." So a provision has to be built in there--

SENATOR MATHEUSSEN: You've given us two objectives we need to address. The first objective is, and it's a hell of a lot easier, excuse me, to change the Administrative Code than it is to do something statutorily by this Legislature, because it takes 120 of us to almost agree, or at least the majority of us.

Administratively, perhaps, we should hear from you about changing the Code for an early removal. That would be not necessarily waiting a year. I mean, if I want to encourage someone to do something, I don't give them a whole year to sit back and not do it. I try to encourage them a little bit quicker, and the heavy hand of going back to the general population, I think, should come quicker than in a one-year period of time of refusal.

To me, one or two times of refusing to visit any one of your counselors -- which you should be the person who chooses, not them -- that's good enough for me to say, if they don't want to cooperate, they can go back and think about it there. That we need to address the Code.

Of course the more pressing problem, and the more concern that we have -- because it all lands back then against the public, and that's what we're really concerned with -- is that moving one of those people into the general population and giving them an opportunity for early parole without having any form of treatment is a very scary situation for all of us.

That is something, unfortunately, that we have to deal with statutorily. I know that is what Senator Bassano talked about before. One of the objectives of this Task Force will be to produce legislation that will prohibit or somehow change that aspect, so they are not going to be given early parole and get

out because they, basically, snubbed their noses at you and the rest of the system and found an easy way out. So those are two objectives.

Thank you.

SENATOR BASSANO: John, I just want to make one comment and that--

SENATOR MATHEUSSEN: I have a few more things, but go ahead.

SENATOR BASSANO: When you said that the therapist should be assigned by Corrections, one of the problems you have is that it is difficult to get a lot of the prisoners to open up and start to speak, and to merely shove a therapist down their throats sometimes creates some problems. I think you want people to get into a program to try to help themselves. Hence, the more freedom you give them to work with a particular therapist, the better it is for that prisoner. So it's not like just saying, "Here is someone, take it," because then the program doesn't work as well as you want. So you have to recognize that a little bit. I just hope you understand that.

SENATOR MATHEUSSEN: I don't disagree with you, Mr. Chairman, but having gone through the academic process, and I'll apply it to that -- whether it be high school, college, or something on a graduate level -- each and every one of us would like to always have chosen one of the professors we liked best, but we don't always get that choice. The course is offered, this is the person who teaches it, and that's the one you get.

Now, you learn after a while that you have to accept certain things, and you learn to look to certain people as your teachers. But I think, initially, for a patient, for an inmate to go into Avenel and say, "Well, I don't like so and so as my counselor and that's the way it's going to be. I don't want him." I'm not so sure that is an option they have, or that we should give them.

SENATOR BASSANO: I understand where you're coming from, but I'm just playing devil's advocate. You want to look at getting the person to open up as quickly as they can, and sometimes they feel more comfortable with other individuals. I can't make that decision. I don't know if you folks can, but I just wanted to point that out.

SENATOR MATHEUSSEN: I have a funny feeling that if they get shifted back to Rahway or Trenton real quick, they're going to think that opening up is probably a better option for them when they get back the second time to Avenel.

MR. PLANTIER: We do allow them that option. We do allow them the option to request and change therapists. Because we realize that not every therapist can work with every inmate and vice versa.

SENATOR MATHEUSSEN: But is that on an immediate basis, or is that something that takes some time to get the adjustment?

MR. PLANTIER: No, no, no. No, we usually require them some time with that therapist to figure it out. What's happening right now, and why you're getting letters, quite frankly, is because people are telling them to write them, number one.

But number two is that change is difficult, and these people have been working with a given therapist for a period of time. They don't like the change. They're unhappy with having to work with somebody else. In many of the cases, the therapist has given that person up, okay, quite freely, and moved on to another area to work. In some cases they haven't, so you have a mixed result, right now. Frankly, if you weren't getting them I would be very surprised. I think you are going to continue to get them for a while, as we're going to get them for a while.

ASSEMBLYMAN MIKULAK: We realize that, Bill, but at least they are communicating with us, which is more than you were doing. (laughter)

SENATOR MATHEUSSEN: Two more things. If you could give me, maybe I missed this before in your previous testimony or even today, help me a little bit more with the process of diagnosis. Exactly what goes on at Avenel to diagnose a new inmate and diagnose one who's currently undergoing treatment?

MR. SAGER: For the repetitive compulsive evaluation at the beginning before sentencing or after the man is sentenced to Avenel?

SENATOR MATHEUSSEN: Chose your weapons whichever one you want to go with. I don't care.

MR. SAGER: Okay. Well, the initial evaluation is the important one because that is the one that determines whether or not they are going to come to Avenel or not to begin with. It also is a report that gives us a lot of information that we could first begin to work with at the beginning of treatment.

Repetitive compulsive evaluation, repetitive is fairly straightforward. There has to be something in the man's record that shows he has committed the offense more than once, or else he can admit to us that he's done it more than once, or he has thought about it more than once. Some kind of a repetitive aspect to it.

The compulsivity has to do with the man's psychological state. We obtain that information through a psychological test battery and also through an interview.

One of the main questions in the interview that we have for repetitive compulsive is, "Did you try to stop this type of behavior before? Did you feel uncomfortable with this type of behavior?" We try to get a response to that. If we get a feeling that the man tried to stop or that the man was somehow pushed, from a psychological standpoint, to commit the acts over and over again, that's the nub of the determination of whether or not the man is repetitive compulsive or not.

An important part of this discussion is the fact that we have to go by the preponderance of evidence, as far as

whether they are repetitive or compulsive. So what we have are a lot of people who we cannot find repetitive compulsive because we don't have enough evidence, but as psychologists we have a pretty good idea that the guy has serious problems. That type of man is found not to be repetitive compulsive, goes into the regular prison system, and probably has a lot of problems underneath, but because of denial or some other issue, does not come to Avenel and is not found to be repetitive compulsive.

That is a hole in our system, because that type of person does not receive a lot of treatment, number one. Number two, a lot of our new laws and a lot of our new notification laws suggest that repetitive compulsive is a part of the notification process. When, in fact, we know that many people are really, probably, repetitive compulsive, but we can't find them. So, I think, I digressed a little bit, I'm sorry.

SENATOR MATHEUSSEN: That's all right, no, no, don't apologize. I think you're here for a very important reason, and that is to help us, all of us, understand what we're doing now and what we could do to improve Avenel or improve the system if Avenel is not part of it.

I have to ask you just two more quick questions. What about the other 70 percent? How much time do they get? You talked about 30 percent, hour and a half, what about the other 70 percent?

MR. SAGER: We try to set our program up -- and again, that was another reason why we looked at the numbers just the other day -- we try to set the program up so that the man could be in therapy five days a week, every day during the regular week. I think we touched upon it a little bit with our three extra psychologists and a little extra work for social workers.

We feel that we'll be able to run 93 professionally run groups per week, in addition to the parapro program that we have. If we do run that many groups, we'll be able to offer therapy for the men who want it. It's always based on for the

men who want it. Again, that's another problem that I have and a frustration that we all have. We don't really know to make people go to therapy. We don't know if we make people go to therapy, if it's going to do any good.

SENATOR MATHEUSSEN: You've been in Corrections for a while, how do you make people do something in Corrections?

MR. SAGER: You try to offer carrots and not just sticks, but carrots.

SENATOR MATHEUSSEN: When the carrot doesn't work?

MR. SAGER: When the carrot doesn't work, one of the things that we try to tell people, try to tell the public is that we have close to a 20 percent failure rate. We always have. We don't know at this point and nobody in the country knows, really, how to lower that much lower. It gets to the point where you have to accept the fact that we can work with some people. We can help some people, and other people will recommit their offenses when they get out. That is the bottom line that, unfortunately, I wish I could give you another answer, but I can't.

SENATOR MATHEUSSEN: This last question--

MR. PLANTIER: We would like a bigger stick.

SENATOR MATHEUSSEN: Okay then, tell us what you need. We need to know that. I think we need something, it's more than just oral testimony. We need to know from you what that other punitive aspect that you need to convince these people that this is what they're going to do. If you're not going to play this game, then there's a better one that they have got waiting for them someplace else.

MR. PLANTIER: I'll tell you right now what's having an affect on Avenel's population, right at this moment-- I think there are certainly other things that we can do in terms of rewards and punishments. But, obviously, the reporting for Megan's Law, the Involuntary Commitment Law is having tremendous

effect on those guys, and it is bringing some people back into therapy.

ASSEMBLYWOMAN WRIGHT: What kind of an affect?

MR. PLANTIER: It is bringing some people back into therapy because they are very, very concerned that--

ASSEMBLYMAN MIKULAK: They're afraid, that's right, fear.

MR. PLANTIER: --you know, it's not the kind of motivation that we would want, but--

ASSEMBLYMAN MIKULAK: It's motivation.

MR. PLANTIER: --at least, if it's bringing some of them back. Yes, we'll take them. But, obviously, whatever we do, we need to come up with better sticks for people like this. I love the idea of aftercare being mandated upon all releases. It being required whether they maxed or paroled. Lifetime supervision-- I think they're wonderful laws. It's too bad that these things have to be implemented, we can't go retrospectively back and make them now, because they will have effects.

SENATOR MATHEUSSEN: One last thing, and this question goes against my own grain a little bit in that because it-- We've heard testimony from Dr. Riscalla. We've heard testimony from others before. We've had a tremendous amount of written documentation on the subject, and that is, no one can say that there is a cure rate or that we're really safe in letting those repetitive offenders out on the street, so to speak. Knowing that, and knowing that my own being, probably constitutionally and probably morally, Avenel or some form of treatment is the right thing to do, in spite of knowing that, is it the right thing to do? Because are we having any effect, are we doing any-- Isn't it just better then to just leave them in the general population? Knowing that it's probably the right thing to do and under the law it's the right thing to do, why bother doing it?

MR. PLANTIER: It's a philosophical issue. Having worked in the program my whole career, I can only answer from what I have seen. I do think we do have effect on some offenders. I do think we have a very positive effect. Frankly, without even throwing out statistics, which can be messed up by anybody and made to say anything you want to, I see a lot of guys go out of there that you never see again. Hopefully, they're not reoffending. You have a lot of people that come back.

I don't know if you want to spend your money doing this, but I think the bottom line is that there are a group of people that are very, very sexually dangerous, and that if there isn't some type of intervention or if they're not locked up forever, they are just going to continue and act out in this fashion.

I don't think there's-- We don't have the perfect cure. We don't have the perfect diagnostic ability. The state of the art is not there. You can't get a psychologist to predict what a future behavior is going to be, because there are so many things that are going to impact on that guy when he goes out to the community. I mean, frankly, right now there is a lot of frustration because people are going back out to the community, and all of the sudden, God knows, they're a third tier notification.

They're being driven from their homes. They're going underground. That's a problem, too, because our concern is that guy may have been well treated. He may have had the wherewithal to survive in an environment if he had some level of support. If he doesn't get that level of support, frankly, I'm very concerned what may happen to him. I mean, I'm concerned he may become a self-fulfilling prophecy.

The other area which I'm very, very concerned is there are a lot more sex offenders out there than you or any of us have ever had a pulse on. There are people out there who

haven't been identified. There are many more out there than we have incarcerated and that we can talk about treatment modalities or lack of same in Avenel about. My concern with them is that they might just be watching what's going on, watching the show, just say, "Well I'm going to get rid of the evidence." I'm concerned that for helping everybody, we may be hurting people. I think they are concerns and I think they all have to be addressed.

ASSEMBLYMAN MIKULAK: Okay.

Assemblywoman Turner had some questions.

ASSEMBLYWOMAN TURNER: Yes, I had two questions. One, regarding Megan's Law, there was one aspect of one of the bills that we passed in that package which, I felt, served as a motivator for these inmates to seek treatment. That was the denial of good behavior credits in terms of a reducing your time served if they don't opt for treatment. Now, have you seen an increase in treatment as a result of that?

MR, PLANTIER: No, unfortunately. I really like the law to be perfectly honest, because it really gave us something right on the scene to smack them on the hands with. If you take away their credits, they do longer time; unfortunately, the law is not retroactive. So, it doesn't apply to any of those people who were in Avenel as of -- was it October 31 when the legislation was signed?

ASSEMBLYWOMAN TURNER: Then we need to remedy that, it should become retroactive.

MR. PLANTIER: Well, if it could be made retroactive I would certainly have a tool I could use now. It will be a tool that I have when new people start coming in and decide not to do therapy. I mean, I will seek some guidelines how to administer it subjectively and as fairly as possible. That has to be worked out. But in terms of a tool, yes, I wish it was retroactive, because the inmates--

ASSEMBLYWOMAN TURNER: Well, I will make sure that it is, because that was something that I was very, very strongly supportive of.

MR. PLANTIER: The inmates were very, very scared of that law. The inmates were very scared of that because that's more time.

ASSEMBLYWOMAN TURNER: Well, the population, too, is very scared of that, too. Because this is what brought us here, the genesis of Megan's Law, of course. One of your more notorious inmates, he was released early for good behavior, and he opted not to take any treatment. So we certainly need to make sure that Law becomes retroactive.

MR. PLANTIER: Something like that. Something like the law of reporting for aftercare requirement and lifetime supervision. I think, if you want to talk about two areas that would really help, in terms of us having a handle, it's going to cost something. You can't get that for free. But really having a handle on the sex offender, providing him an aftercare setting to go to, and mandate that he go to, whether he maxes out or is paroled, I think, is going to help us help the State. That and obviously an internal process such as denying them commutation time for failure to receive therapy is a very nice, handy tool to have.

MR. SAGER: I'd like to give you just a little bit of feedback on that, too, because I deal with these people everyday. When the new guys are coming in and we tell them -- when it seems like they're not too hepped up on therapy -- we tell them that they might lose time if they don't go to therapy. You can see the difference in their attitude right away, so that's obviously helping.

The other thing that we could say, as a result of these new laws, is that we write a report on you around the time that you're going to get out. That's going to have an impact on the notification process. So, if you want your entire community

to know that you're getting out, it might. If you don't want them to know, it might be a good idea for you to do therapy while you're here, so that we could provide a good report. And we could say that you changed while you've been here. That too, I think, just day in and day out as we eyeball these people, we could see that's having an effect. Those two things are very significant at this point.

ASSEMBLYWOMAN TURNER: Important that we keep in mind that this facility is supposed to be for treatment. It's not really to provide any kind of punishment, if you will. I think of a regular prison as one that would provide or mete out punishment, but if they are going to be there, then they should be fully engaged in treatment. Because these people are, in my mind, they're sick. I don't think you really punish sick people because how much-- I mean it doesn't do you any good if they're sick, punishing them is not going to help. I think we come back to the question of whether or not these people can be treated successfully and whether or not they can be rehabilitated.

My second question is going back to credentials, Dr. Graffin, could you clarify for me, I wasn't quite sure, you said you had your doctorate and that's in psychology?

DR. GRAFFIN: Yes.

ASSEMBLYWOMAN TURNER: What was the oral examination you said that's pending? What was that for?

DR. GRAFFIN: Right. The licensing requirements for psychologists in New Jersey includes a written case sample followed by an oral exam. That's the final step in the licensing process. I submitted my written case in July, and I'm waiting to have my orals scheduled. So that's--

ASSEMBLYWOMAN TURNER: You indicated your experience was more or less in terms of working with victims and also to some extent with offenders.

DR. GRAFFIN: Right.

ASSEMBLYWOMAN TURNER: Could you be more definitive, in terms of the length of time you worked with these two groups and also your employer, where you worked with them?

DR. GRAFFIN: I originally worked with offenders and survivors at the University of Medicine and Dentistry in Piscataway, that was, I guess, about five years ago. Then, my last position, I worked in an outpatient mental health center that had a treatment team specifically geared toward working with, again, primarily survivors but also with offenders. In terms of--

ASSEMBLYWOMAN TURNER: But what was the length of time, how many--

DR. GRAFFIN: Five years, altogether.

ASSEMBLYWOMAN TURNER: Five years, between the two?

DR. GRAFFIN: Right.

ASSEMBLYWOMAN TURNER: Okay, thank you.

ASSEMBLYMAN MIKULAK: I have a request for you people. How many people are serving in Avenel with sentences of 20 years or greater? You can give me an approximate but get the Task Force the exact number.

MR. PLANTIER: I can get you that number. I didn't bring that statistic with me.

ASSEMBLYMAN MIKULAK: Okay. That's--

DR. BROOKS: I'd like to raise an issue that concerns me. That is, that in your presentation you seem to feel that any coercive measures that can compel an inmate to accept therapy are desirable. Now, you have a lot of inmates who refuse completely, perhaps a third. You also have inmates who accept only an hour and a half a week and that's about a third. So you have two-thirds of the inmates who are either totally refusing or accepting the minimum amount of therapy.

MR. SAGER: No, those numbers aren't right--

DR. BROOKS: Now, let me continue, you can rebut it in a minute.

The literature in the field is replete with the idea that enforcement of therapy does not work. That it simply doesn't pay to compel persons to accept therapy. What is likely to happen in many cases, and there is an enormous amount of literature on this, is that the inmates fake it. In order not to lose their good credits, they don't accept therapy as much as they go through the motions of saying, "Okay, in order not to lose my credits, I'll go into therapy."

It seems to me that you have a settled attitude and Mr. Plantier expressed it, "Oh, we'd love to knock them over the head." As though you can really get results by knocking these inmates over the head with some kind of club and say you have to accept therapy in order not to lose your credits, etc. I would like to suggest that this is an illusion. It's important because, for one thing, the Legislature has already enacted a statute. There seems to be a sense among some people, some legislators here that it was a good thing and perhaps it ought to even be enhanced. It ought to be made retroactive rather than just of a time.

How do you confront the fact that virtually every responsible researcher and scholar in the field says this is not the way to do it? You're just going to get fakery, you're going to get con people? How can you reconcile that enormous amount of literature with your view that this is a good thing, to club these people into therapy? Because, actually, if this Task Force is interested, as I believe it is -- some people on this Task Force, if they believe in preserving Avenel at all or preserving the function, feel that you should cut out all the refusers. Get rid of them. Get rid of all the tokenism.

Then, give therapy only to those that are motivated-- You yourself, Mr. Sager, referred to the fact that it's difficult to get people to be motivated. You acknowledged that there are a lot of people not motivated. If, indeed, one of the approaches of this Task Force that is before it is to provide

therapy for those sex offenders who are really motivated -- which is a small proportion of the number of inmates you already have, maybe 10 percent, 15 percent, 20 percent -- to force inmates to go through the motions of appearing to accept therapy is to defeat, it seems to me, the very objective that a lot of people on this Task Force may have.

MR. PLANTIER: I didn't mean, with my remarks, to say that I was trying to force them, to club them to do therapy. As a matter of fact, as I spoke earlier, the best way to do therapy is to do it with somebody who is clearly motivated and wants to change.

DR. BROOKS: Except that you just said, "You'd be delighted if it could be made retroactive--

MR. PLANTIER: I would be delighted.

DR. BROOKS: --and you could just get all these other people to accept therapy."

MR. PLANTIER: No, no, you misunderstood. I would be delighted because then they would do longer sentences. Then they would, in effect, be doing day for day sentences. They would be serving a much longer sentence than originally designed.

DR. BROOKS: But would they not offer themselves for at least an hour and a half of therapy every week? That would be a small price for them to pay to go through these motions in a phony way--

MR. PLANTIER: What I said--

DR. BROOKS: --just simply not to lose their good time credits.

MR. PLANTIER: What I said is procedures would have to be developed so that we could subjectively evaluate that, so you could apply it objectively as best we can. What I would want-- The law is specific. It says to do therapy, it doesn't mean just sit there. So it's going to have be more of a report-- It's going to have to be a better report than just saying,

"Well, he sat there and he comes to all therapy groups." It's going to have to be a psychological report saying that he's working in therapy. He's working on his own issues. He's doing therapy. Now, if that's what got him motivated, you know, fine and dandy, but the basis of having the tool is to hold people as long as possible who are not going to be motivated, who are not going to do therapy. The law doesn't say that they just have to show up. The law says that they have to do therapy while they are there.

DR. BROOKS: You're representing to us that the therapists will, in good faith, report and say, "This guy is not doing this is good faith, and therefore, he is for all practical purposes a refuser."

MR. PLANTIER: I can't--

DR. BROOKS: "He's just going through the motions." This will be reported? Because a lot of the inmates have reported to us that the administration of Avenel is eager to have as many non-refusers as possible and go through every conceivable kind of manipulation to show that someone is not refusing.

MR. PLANTIER: No, I don't think that's true. I can't tell the psychologists, and I don't think it's appropriate for me in my role, to tell the psychologists who to make therapy refuser and who not to. Obviously, there's some subjectivity there in who's going to be made and who's not. There are guidelines for making people therapy refusal, and there are guidelines for taking them off therapy refusal.

So I can't speak to every instance, but I do think we have some mechanisms in place that can handle that. In terms of forcing them back to therapy, no. I mean, if I had to come here and tell you that 150 of the 740 weren't doing therapy, then that's what I'd come in here and tell you. The fact that it happens to be 44 or 46 as we speak today or maybe it has gone up

a couple, that's what I'm going to report. If they want to stay that way, fine, let them stay that way.

We'll continue to try to motivate them to do therapy because that's our job, but we're not going to force them. If they find that gee, they can find some motivation in the fact that they're going to be spending a hell of a lot more time in Avenel than they thought, if that's the motivation to get them started, and they actually happen to do therapy because of that, then, I think, we've succeed to some degree.

It may not be the most purest sense of motivation, but if they are doing therapy, they are talking about their issues, and they are working on their problems, they are still doing that.

DR. BROOKS: You think that's worthwhile enough, to justify--

MR. PLANTIER: I think given what we have--

DR. BROOKS: --to justify the fact that there's going to be a lot of phonism, and that a lot of people who should be shipped out of Avenel are going to continue to stay there and occupy beds?

MR. PLANTIER: Oh, I have no problem shipping them out if they don't do therapy. That's not a problem at all, you know, as long as they stay incarcerated.

SENATOR BASSANO: Bill, you had a question?

I'm going to ask that we try to move it along quickly. There are five more speakers. I want to break for lunch, and there are two more groups that want to address us. So let's try to move it along a little bit.

Bill.

MR. THOMAS: I'd like to make the statement about two different items. First of all, Megan's Law is not going to be retroactive. We haven't accomplished a thing, nothing, because nothing will happen for another seven years or whenever the

first offender leaves prison. So that has to be changed or we may as well give up on that for the next ten years.

Next, it was stated that some people think punishment shouldn't be a part of the sex offenders treatment and rehabilitation. I couldn't disagree more. I think that's the way you get their attention, put them in prison. When you think they'll respond, take them out and give them the opportunity, and it is an opportunity to take treatment. You don't need your 200 or 300 who are in Avenel accepting nothing except TV and three square meals a day.

Now, we haven't had an evaluation program in New Jersey, but I've taken it upon myself to make calls around the country, and I've talked to a number of psychologists from all over the country. I've talked to two different states. Now, the State of Virginia, they did have an evaluation. They are discontinuing their sex offender treatment as of June. Now, I'm not going to say it was only because of a lack of effectiveness of the treatment, it's also dollars and cents. I was also referred to the State of California. They just finished a five-year study. As of June, they will discontinue their respective treatment in that state.

So other states looked at it, we tried, maybe we're still trying, but I have to ask you, since we don't have an evaluation, how you, as the administrators of Avenel -- maybe this is not a fair question, but I'm going to ask it anyway -- would feel if one of the treated prisoners, now this is a treated prisoner, was released in your neighborhood with your young children under the present situation, no follow-up, no nothing, how would you feel?

MR. PLANTIER: I'm a father of two.

MR. THOMAS: Okay, that answers it, right.

MR. PLANTIER: Obviously, yes. One of the things that has me in the business and has been so long is because is we don't like to see victims. Protectionist society is our number

one issue, everything else just goes behind that. So, the devastation that I would feel, I'm not going to share with you.

MR. THOMAS: Okay.

MR. PLANTIER: But, suffice it to say that I could certainly understand what a parent may be going through. What we're trying to do is, to the extent that we can, with the resources provided us and with the limited state-of-the-art of knowledge of doing this, we're trying to prevent victims. We're not trying to get people out there quick. So our conservative program, which we've been criticized for also--

MR. THOMAS: Bill, I'm not criticizing you. I think it's something that we always have to think about.

MR. PLANTIER: It hurts. I know from working there for many, many years it hurts the psychologists tremendously. They become devastated when one of their people comes back. I mean the last thing we want is to see more victims. I wish there was a way we could tell you that there's something that we could do so that there wouldn't be any more victims, but aside from shooting them, there's nothing else I can tell you.

MR. THOMAS: No one has been able to say that, but I think what we have to all try to do is to -- the people in this room -- is to protect our population. The people that are innocent are the ones that require to be protected.

MR. SAGER: I'd like to answer that, too, just on a personal basis myself. I was at Avenel when the man that was accused of Megan Kanka's murder was there. I participated in part of his treatment or the treatment that he, at least, was willing to accept. When this happened, I had to ask myself some very difficult questions. One of the feelings I had to deal with was the feeling of revulsion that you often get when you work with sex offenders, but I never had it the way I had it after this.

I simply had to ask myself the question, "What are you doing here? Why are you staying with this and should you stay

with this at this point?" My eventual answer that I answered myself was, "I can't run away from this situation for one reason: I think that what I'm doing is helping to prevent future victims." I feel like I'm working for future victims. I'm working for people who would be future victims if this treatment didn't happen. So I asked myself that question, and it really wasn't an easy situation for me and I'm sure for everybody else there. That's what I came up with personally. MR. THOMAS: Thank you.

I feel that it's the responsibility of all of us -- in this room and part of this panel and the administrators of the institution, as well -- because we have to protect the kids, the public. I have a special interest, as you know, I'm the grandfather of Amanda Wengert.

Thank you.

SENATOR BASSANO: John.

SENATOR GIRGENTI: Yes, just very quickly, Lou. Most of this stuff has been touched on. I just want to get a clarification, you never really answered the question. Professor Brooks said we're talking about the 30 percent. The 30 percent that are treatment refuser. Are they any part of your count, or is that 30 percent out of that? In other words, it's not 30 percent treatment refuser, 30 percent hour and a half a week, so that's 60 percent maybe?

MR. SAGER: No.

MR. PLANTIER: No, there are only 46 therapy refuser or 44, as we speak today, some number right around there, so that's all there are.

MR. SAGER: The percentage goes up when we talk about the people who just seem to be going through the motions. There's no point in denying that. I always threw out the percentage of about one-third of the people didn't seem to be interested in therapy at Avenel. The other two-thirds I felt comfortable working with and making progress, but there did seem

to be the third that I wouldn't be very surprised if they didn't get much at all out of the program. I think that's probably a pretty realistic and workable number as far as people--

SENATOR GIRGENTI: Now, you're mixing me up even more.

MR. SAGER: I'm sorry.

SENATOR GIRGENTI: Treatment refusers are people that do not want any part of treatment at all.

MR. SAGER: They absolutely refuse and do not come to any kind of group.

SENATOR GIRGENTI: All right, is that one-third of the facility?

MR. SAGER: No. That's 40 inmates, 50 inmates.

SENATOR GIRGENTI: Okay. Now you're talking-- So you're saying 40 percent to 45 percent are the treatment refusers.

MR. SAGER: No, no, no.

MS. VASILE: No.

MR. SAGER: Forty inmates, 44 inmates out of 740 are treatment--

SENATOR GIRGENTI: Are the treatment refusers, right.

MR. SAGER: --are treatment refusers, not 40 percent.

SENATOR GIRGENTI: Okay, maybe I didn't say it right. So, one-third is what? People who just participate but you don't--

MR. SAGER: As a therapist, I would say that there are people who don't actively involve themselves. They will come to group, they're probably the group that come the hour and a half a week. They'll come to group. They might be coming to group to make it look good, but they don't actively participate. They don't seem to be really involved in it or motivated in it.

SENATOR GIRGENTI: So what you're saying that -- these 40 people that do not want anything at all, what is presently happening with them? You're saying that for a year you keep them there? What happens after the year? Are you sending them

to prison or are they just staying there for their whole term? Maybe superintendent--

MR. PLANTIER: What we're doing right now, unless the case is so disruptive to the program as a whole or to the institution as a whole, we're keeping them. We're not transferring them out. That goes back to what I mentioned earlier that when we did transfer them out, it only generated more because those people have parole dates and were released.

SENATOR GIRGENTI: Okay, Bill, what are they doing there?

MR. PLANTIER: What are they doing?

SENATOR GIRGENTI: Yes, do they just sit around?

MR. PLANTIER: They receive less privileges than the bulk of the population. They have jobs, but I talked about jobs before. Yes, for the most part they are not doing a hell of a lot more than nothing. You know, some of them may put their energies into work and work real hard.

SENATOR GIRGENTI: That could be done in a State prison.

MR. PLANTIER: Oh, yes. The concern that we had, and the concern that I continue to have is that the judge specifically sentenced the case to Avenel. He doesn't suggest it, he specifically sentences a case to Avenel. To transfer a guy out quickly just because he hasn't done therapy, you're really flying in the face of the judge's sentence and thwarting his sentence. So we don't like to do that.

The other concern is, you know, in a regular State prison environment many of these guys are going to look like ideal inmates. The parole board is going to become very, very easily fooled by them, and they're going to go back to their community untreated. That is found out by the rest of my population which, I guess, that means more people drop out of therapy for the same purpose.

ASSEMBLYMAN MIKULAK: But the judge put them there in the first place because of the recommendation from Avenel. Is that not true?

MR. PLANTIER: That's right.

ASSEMBLYMAN MIKULAK: So--

MR. SAGER: Well, we don't necessarily recommend that they come for treatment. What we have to say is that they're repetitive compulsive. A lot of times we find them repetitive compulsive, and we have a pretty good idea that they're going to be very resistive to treatment, but again, we're following the law at that point.

SENATOR GIRGENTI: Just one final question. When we first appeared, you know, we said that there was really no yardstick to go by, as you originally mentioned, because of the fact that we do not have recidivism rates in the present time or the near past. Are you doing anything about that with this whole new change? Are we now making that information? Are we gathering that kind of data?

MR. PLANTIER: We've recommended to this panel that a research group be established within Avenel to start doing this data. We are, as we can, culling out data but it's a very, very slow process. We have limited staff and we have a primary obligation to provide treatment. So, what we do, we do on the side. If we get some volunteers or interns we put them to work. But it's really a hit or miss process.

SENATOR GIRGENTI: But you know to evaluate the program that's--

MR. PLANTIER: We would very, very much like to have some evaluation of the program. We would like to have -- and what's been presented to this Task Force -- is a request for some research, people to do some basic research in the program, to give us some hard data. The Department doesn't keep hard data on us. We have been just hit or miss, as we have the time, and when we lose staff we don't have the time. But, as I said

in the past and I said it the last time I appeared before this hearing, I think it's a very, very valid criticism. I can't present to you hard data when I don't have hard data. It's not because I don't want to tell you what we're doing, it's just because I don't have it to give you.

SENATOR GIRGENTI: But, you know, as we said, that's the first thing you look for when you go to evaluate a program.

MR. PLANTIER: Sure. So what I would suggest is, if you really want to look at this program down the line, let us do some research. Give us the money to do some research, then turn it over to you, and then you can see what we're doing. But the changes in the program will provide one thing that we haven't had before, and that is a pretest/posttest for some of these modules that we were doing. That, while it won't give us research, per se, will give us a basis and give us some information to do research with. It will also allow the individual psychologist to make a determination of whether that individual got out of that particular module what we had hoped he would obtain out of it. So it does, to some extent, give us something that's basically a tool we can work with in the future. So it's a start, it's not much more than that.

SENATOR BASSANO: Assemblywoman Wright.

ASSEMBLYWOMAN WRIGHT: I wanted to address my comments to Dr. Graffin. I heard one of the other staff mention Dr. Steele's consultation, and that it came about after 1991, a grant from NIC. I don't know if you can help me but some of this is technical, but the other piece is going to go into-- I want to talk about treatment with you.

Dr. Steele's paper that is in materials here, and I was not on the Task Force the first session, so I didn't hear it all. I haven't read it since, because I just got it. But she reported on the recidivism of sex offenders, is the treatment program cost-effective?

Whereas, Mr. Sager, you mentioned that you shifted from behavioral to cognitive therapy. So one of my questions is when did -- something about Nancy Steele's consultation here, what was the magnitude of it? When did she report to you, so that you made the decision? Because it sounded like one of you said, "It's like since, certainly '92, '93 and '94 you've been in a dialogue over your treatment," if I got that straight? Maybe I'll stop there and let's clarify what you did, in terms of these last three years with a grant from NIC? Maybe you can't answer, maybe--

DR. GRAFFIN: Right, I can't.

MR. SAGER: The dates are a little bit off. We met Dr.--

ASSEMBLYWOMAN WRIGHT: I'm going by what I heard here.

MR. SAGER: We met Dr. Steele in February of last year, of 1994.

ASSEMBLYWOMAN WRIGHT: But you said you had a grant in 1991 from NIC, is that correct?

MR. SAGER: No, no, no, not in--

MR. PLANTIER: The grant was in '94.

ASSEMBLYWOMAN WRIGHT: Oh, okay. Did I take a note then incorrectly, 1991 you were not having a dialogue about changing the treatment plan?

DR. GRAFFIN: It was September 1993 that the Committee of Psychologists started to meet and talk.

ASSEMBLYWOMAN WRIGHT: Okay, good. So September of '93, then Dr. Steele came about in early 1994?

MR. SAGER: That's right. In May of 1994, she visited us for a week and observed our program.

ASSEMBLYWOMAN WRIGHT: Okay, but this is all part of the psychologist's interest in making modifications.

This document that is in our materials, her paper on cost-effectiveness, is that something she did for that consultation?

MR. PLANTIER: No. That's a paper that she had done and she had provided us and we, in turn, provided the Task Force.

ASSEMBLYWOMAN WRIGHT: Okay. Was she a continuous consultant over--

MR. PLANTIER: No. She does consulting work for a number of states out of the National Institute of Corrections, but she was the head of the program in Minnesota, the sex offender treatment program in Minnesota, and now she is in Ohio working there in a program.

ASSEMBLYMAN WRIGHT: I was trying to get a feel for how you-- I mean, did she work along with you over this past year, and then you got a report that you sent to Commissioner Fauver as a result of the September '93 group?

MR. PLANTIER: I guess I can explain it simply. When Mr. Sager and Ms. Rogers went out to the NIC in Colorado for that week of training, they met with her.

ASSEMBLYWOMAN WRIGHT: When was that, roughly?

MR. PLANTIER: That was, I believe, in February.

MR. SAGER: February.

MR. PLANTIER: February of last year.

ASSEMBLYWOMAN WRIGHT: Of '94, okay. I have it. I was trying to get the parameters of that.

MR. PLANTIER: That established that dialogue with Dr. Steele. I know Ms. Rogers had numerous conversations with her since that time, and it resulted in her obtaining an NIC grant -- Ms. Rogers getting the NIC grant to bring Dr. Steele out for a week in May to actually come in, talk to the therapists, look at the program, sit in on groups, and then provide a report to the Commissioner of the Department of Corrections on her findings.

ASSEMBLYWOMAN WRIGHT: When was that report completed, from September of '93 this went on through--

MR. PLANTIER: I don't know if I have the report with me, but I think the date of it was, like, maybe June or July of '94.

ASSEMBLYWOMAN WRIGHT: Oh, okay. So that was on the Commissioner's desk for six months before he gave you the authority to make the changes based on it. Because you told me that December of '94 is when you got the authority.

MR. PLANTIER: Yes, the Commissioner was well-aware of this report in June of '94.

ASSEMBLYWOMAN WRIGHT: I just want to know when the report was submitted to the Commissioner.

MR. PLANTIER: June of '94 is the date, June 8 of '94.

ASSEMBLYWOMAN WRIGHT: He acted on it in December of '94?

MR. PLANTIER: I can't speak for him.

ASSEMBLYWOMAN WRIGHT: No, no, you told me.

MR. PLANTIER: I can only say that I requested permission in December to initiate those changes and I received it.

ASSEMBLYWOMAN WRIGHT: What happened between June and December, is what I'm asking you then?

MR. PLANTIER: With us or with--

ASSEMBLYWOMAN WRIGHT: Well, you submitted-- Do you follow my thinking?

MR. PLANTIER: I'm trying to.

ASSEMBLYWOMAN WRIGHT: Oh, okay, I'm just looking because I think this is important for our sequencing. You were in a dialogue over changes in your program for six months before a report went to the Commissioner in June. You correct me.

MR. PLANTIER: No, that's correct.

ASSEMBLYWOMAN WRIGHT: So, from June, I was trying to figure out what happened between June and the Commissioner's authority to implement that report. His senior staff reviewed it, is that what was going on between June and December?

MR. PLANTIER: I can't speak for the Commissioner. I can speak for what we were doing. I don't know what the Commissioner may or may not have been doing with it. I don't think he was doing anything particularly with it, except being aware of it. What we were doing, we were then-- That Revision Committee was continuing to meet, now with that report, make recommendations.

As Dr. Steele said, there was a lot of give and take on both sides, trying to figure out better ways to do this. That went on until such a time as I received a request from the treatment staff, I believe in late November or early December of '94, that we would like to do this now.

ASSEMBLYWOMAN WRIGHT: I just have to ask you one other question, and it's not exactly on the professional side. There are lot's of ways in which you treat people. When I first understood that this was a treatment center, Dr. Graffin, I thought this was an inpatient treatment center, you know, like a 30-day rehab. I thought people would get, you know, seven hours a day of treatment, five days a week like you do in rehab. What's the-- Have you looked at the history here at all, or is it something to do with the state of the art of treatment that everything is done five days a week, one and a half hours a day on an outpatient?

I mean, one of the inmates here testified he was in Johns Hopkins for a 30-day treatment and he was a child molester. Is a 30-day intensive treatment plan, is that being used anywhere today or is it not used by the prisons? Can you react to that as opposed to the-- I just figure for the amount of time people are here, and supposedly this is a treatment center, I thought that treatment would be the focus.

DR. GRAFFIN: It's my understanding that the program is structured within what the law is mandating us to do. We're mandated to have these men for the course of their sentence, and

since their sentences can be five years, seven years, thirty years--

ASSEMBLYWOMAN WRIGHT: You can plan their treatment accordingly.

DR. GRAFFIN: Right, and you're not going to be able to provide somebody with seven hours of therapy, five days a week--

ASSEMBLYWOMAN WRIGHT: Well, it wouldn't matter.

DR. GRAFFIN: --for seven years.

ASSEMBLYWOMAN WRIGHT: That's right. I guess what it brings me to is the question of should we have people not waiting to come for 30 days? But it leads to the discussion we had earlier about should there be incarceration in a punitive sense? When the readiness level is there, and you decide all that in the prison, then bring people into a treatment center. I think that's one of the things that we have been batting around here as to how effective that would be and if that's a model used anywhere else?

DR. GRAFFIN: I think that it would probably bring us into a situation where our treatment program would be more similar, in terms of time frame, to the ones that you'll see in the literature where treatment may be over a three year to five year period. If that answers your question.

SENATOR BASSANO: I think that's the direction this Task Force seems to be going in.

ASSEMBLYWOMAN WRIGHT: Thank you.

SENATOR BASSANO: I have two other speakers. Very briefly, Senator Inverso.

SENATOR INVERSO: Yes. You indicated earlier that to be admitted into Avenel you have to be classified as compulsive repetitive type. Relative to your evaluation at the end of the spectrum, do you have any statistics that you could share with us as to how many are still classified as compulsive and repetitive upon release?

MR. SAGER: You know, I've never been in a mode to evaluate that specific referral question at the end of somebody's treatment. At the end of the treatment, what we try to do is to determine the risk level when someone gets out. If he's still risky to commit an offense again, whether or not the psychodynamics are still intact at the time when someone's ready to release so that he be repetitive compulsive, probably would be a very similar evaluation. So, I think, probably the percentage of people we put up for parole -- that we feel who are now ready for release under good supervision -- would probably be the number that we would consider no longer repetitive compulsive.

SENATOR INVERSO: Could you rephrase that? (laughter)

I understand that the history, as you indicated, is a major ingredient in determining whether someone is compulsive and repetitive. I understand that if you have them for six years, seven years, eight years, or however long you have them that they don't have an opportunity to display or demonstrate their compulsive and repetitive nature.

But from a clinical standpoint, when that person is being released, and this is basically the genesis of Megan's Law, we need to know whether you fulfilled your mission, one, and we need to know if you haven't, who they are that are still the compulsive repetitive types. So you're telling me that at the tail end that focus on whether someone is compulsive repetitive is not what the diagnostic evaluation is meant to do?

MR. SAGER: What we want to do is to give, and what we're doing now since the initiation of Megan's Law, is give a report, as good a report as we can possibly give, to determine whether or not the man continues to be a danger and at what risk level he's a danger. So, since October, I believe, or November, we've been writing termination reports of a different kind from the kind we used to write. These termination reports are written with the idea that they'll go to the County Prosecutor,

and they'll give the County Prosecutor as good of an idea as we possibly can, since we've been treating this man for years, as far as what his risk level is. We have been doing that month for month. I don't know if I'm answering your question or not?

SENATOR INVERSO: Yes you are. We're getting there. But the risk level for a tier three is compulsive and repetitive -- primarily, my way of thinking, I was very closely involved with this legislation -- so now your evaluation, in terms of risk assessment, is focusing on low, moderate, and high?

MR. SAGER: Yes.

SENATOR INVERSO: Therefore, you are looking at the compulsive and repetitive potential or degree in the person being released now. We weren't doing it before, I'm not putting words in your mouth. But I'm trying to determine, because the question I have next is, and you alluded to it, what has changed since Megan's Law? How has it changed? You know, it's too soon to tell, because we have, obviously, the court holding up some of the notification-- (indiscernible)

MR. SAGER: The major change that I could tell you about is that this report is being written. It's being written 90 days before the man is getting out. It's going to the prosecutor of origin or to the prosecutor of the county where the man says he's going to move to. So our best--

SENATOR INVERSO: How many have you written, roughly, since December or January?

MR. SAGER: About 40 or so releases, probably 50.

SENATOR INVERSO: Forty. Then again, I don't want to belabor the numbers, I understand it's hard, but how many would be the high risk category, in your opinion, percentagewise?

MR. SAGER: Maybe 10 out of the fifty, maybe 20 percent. Bill, I'm off the top of my head.

MR. PLANTIER: Maybe not even that high. But there are I can recall probably at least five people.

SENATOR INVERSO: Okay, does that mean you guys are doing the job?

MR. PLANTIER: Well, yes. I guess if that's how you want to judge it. The bulk of the cases that we would send out-- You see, we don't assign the risk to it, that's the prosecutor's job. So we have no idea what it's actually going to end up when we have it.

SENATOR INVERSO: Yes, but I thought Mr. Sager said that you were.

MR. PLANTIER: No, the prosecutor's job is to assign the risk. We provide them with the package and the reports. We would note in there the high risk features that we see.

SENATOR INVERSO: Okay, so you actually don't make the classification--

MR. PLANTIER: No, we can't make that.

SENATOR INVERSO: --you just provide the parameters of risk?

MR. PLANTIER: The bulk of the cases we would see are probably tier one, tier two. But I can recall quite a few that, you know-- I don't want to give it a number because that almost sounds-- I can recall, probably, about five that are clearly tier three.

SENATOR INVERSO: But what I'm getting to is at the beginning of the process they're compulsive, they're repetitive, they are of the worst sort. Now, after their stay in Avenel, your evaluation of the risk, your assessment of risk indicates that the compulsive repetitive type, which I would consider to be the tier three, which would require neighborhood notification, is only 20 percent. Does that, again, prove that Avenel -- in spite of all of the problems and in spite of the limited resources and all the other things we've heard about -- is doing the job?

MR. PLANTIER: We honestly--

SENATOR INVERSO: You're pejorative in your answer but I need to hear it.

MR. PLANTIER: Yes, I know, I mean exactly. I hadn't thought of it to be perfectly honest. But, yes, most of the cases go out with prognosis that if they attain aftercare that they have a chance of making it in the community.

SENATOR INVERSO: The key ingredient, right, the aftercare? We know it's not there the way it should be. That poses a risk to the community and to the individual, certainly. That's a key qualification then, on the risk assessment, the availability of aftercare?

MR. PLANTIER: We recommend aftercare on every case.

SENATOR INVERSO: On every one?

MR. PLANTIER: On every one.

SENATOR BASSANO: It's all voluntarily.

MR. PLANTIER: Except for parolees. Parolees it's mandatory, but there's not very many of them to speak of. But on every case when they max out, we strongly recommend them to involve themselves in aftercare. The premise being that, you know, we're treating them in a closed institution, their ability to act out, their ability to be deviant is just not there. So you're providing treatment in, really, an artificial environment.

SENATOR INVERSO: But was that question the assessment then of risk? If it's initially based on history as we said, their ability to be deviant is limited to a great degree.

MR. PLANTIER: I mean, it's the same reason why we don't bother using anti-antigens; it's not because they're not good, it's just because they are not at risk to reoffend. But, I think--

SENATOR INVERSO: How much does that influence the assessment? And is the assessment valid based upon that inability to truly make the determination from a historical

standpoint, certainly, but I would hope that you can do it clinically, or can't you?

MR. PLANTIER: I think for a psychologist to predict future behavior it's damn near impossible, and I'm not a psychologist, but I think they will all tell you the same thing. But I think what everybody is looking at is that the guy was participating in therapy, he appeared to have gained this, this, this, or this. Deficiency areas may still remain this or that, but with aftercare and follow-up, his risks of reoffending are going to be sufficiently less.

SENATOR INVERSO: Yes, but I guess the bottom line is that we really don't know. That's not meant to be a criticism. I mean, again, there's no finger-pointing going on here. I think several of the members of the Task Force have indicated that, in spite of how the session began, but there's no finger-pointing, we're in this together. We're looking to do what we have to do to make this system better: to protect the community, certainly, and to render effective treatment and also the punitive aspect. But we can't polarize ourselves and say "you" and "we." You are the bad guys and we are the good guys because we're asking these questions, no we're not. We share as much of the guilt for the problems that exist as anyone, but can we truly say that we don't know?

MR. PLANTIER: Yes, we can truly say that there are no guarantees. I mean we are working with them in an artificial environment. When they go back to the streets, to the communities, and to the families if they have them, where they came from, we can't predict how they are going to be received. We can't predict if they are going to be accepted. Most normal people that you work with and deal with are not going to want you throwing a lot of therapy at them 24-hours-a-day or talking therapy to them, which is what they have been doing in Avenel for so many years. We can't predict that they are going to get jobs. We can't predict if they're going to go back to drugs --

the only thing that we can do -- or alcohol-- The only thing that we can do for them is to hope to have a network out there, so that when they are having problems, hopefully, that they will have enough sense and enough wherewithal and recognize their warning signs. That rather than acting out, they'll come seek us out and ask for help. I think that's really the best you can hope for. There's nothing that we can ever do that's ever going to give this Task Force or us or anybody a guarantee.

SENATOR INVERSO: No, we understand that. There are no guarantees in life. We understand that clearly, but it's a question of how we are approaching it. What exists right now, in terms of the evaluation, in terms of the information that is going to the County Prosecutors, is enabling them to make a fair and, you know, reasonable determination of risk.

Because, you know, we've seen what's happening. The law is just going into effect, it's just too early. We're seeing what's surfacing, I think, is just an inability to properly make a determination of risk and that is the classification notification. To play it safe, we may be saying, you know, everyone should be a tier three, and that's not the intent of the law. If that continues, it could undermine the effectiveness of the of the law. That's a concern to me. But I was just wondering what you're doing now that's different to help, with regard to the notification aspect of the law?

MR. SAGER: Well, we're writing the report, and we're writing as long and as detailed a report as we can because we know how serious that decision is. The other thing I'd just like to mention, aftercare not only provides a treatment aspect to it, but an evaluation aspect to it. Because when you have someone in aftercare who's supposed to be coming in every week, what you find, in practice, is that they usually stop coming to aftercare before they act out sexually. They'll start to use drugs before they start to act out sexually. So we have a process, if we're watching them, where we'll be able to catch

them before they do something serious or before they seriously victimize somebody else. We've seen that time and again with our aftercare program, that we've been able to identify that and do something about it.

SENATOR INVERSO: Well, certainly that's another area that this Task Force, obviously, will hone in on, in terms of the aftercare legalities and what has to be in place to make sure it works effectively.

Okay, thank you very much. I appreciate it.

SENATOR BASSANO: Last question before we break, and that's Assemblyman Malone.

ASSEMBLYMAN MALONE: In your professional opinion, Doctor, how long, really, do you feel somebody should be at Avenel, I mean, on an average. I mean, not 30 years, but not two days.

DR. GRAFFIN: It's a difficult question to answer because you're talking about a broad range of presentations. We have men who are repetitive pedophile, all the way through to men who are repeat rapists. But if you were going to try to sort of lump it all together, I would say that the literature supports about three years to five years for a treatment program.

ASSEMBLYMAN MALONE: The issue of credit for good behavior, is there a criteria for that? How do you assign somebody good behavior?

MR. PLANTIER: Good behavior is something that by statute how it works now is they earn it automatically, unless it's removed for some disciplinary sanction within the institution. So it's an automatic process that, matter of fact, they have it taken off their sentence -- I'm not just talking about Avenel guys, I'm talking about all State prisoners -- the day they are admitted, that calculation is done in terms of commutation time. The only thing that can happen is they can lose it for bad behavior. So it's something that is

automatically granted, they get it the day they come in the institution.

ASSEMBLYMAN MALONE: Okay, so it's up front that they get their good credit time, and it only can be taken away from them.

MR. PLANTIER: They get it up front, and the superintendent is the only one who can take it away from them.

ASSEMBLYMAN MALONE: Just following up on Assemblywoman Wright's question, the report that you had was submitted to the Commissioner on June '94. It sat on his desk from June '94 up until you made the request that it be implemented.

MR. PLANTIER: Yes.

ASSEMBLYMAN MALONE: You made that request that it be implemented in December?

MR. PLANTIER: Yes.

ASSEMBLYMAN MALONE: Why in December and not in July, August, September, or November? I mean it just seems coincidental that this Task Force gets together and all of the sudden, you know, the alarm goes off.

MR. PLANTIER: I apologize for the coincidence. It wasn't intended to be a coincidence. It had been discussed. I knew they were in the process of doing it. I knew it was going to come to me. I didn't know when it was going to come to me, because personally myself I didn't involve myself in the process. So, when it came to me, we looked at the timing and the timing looked good to implement it. Not because this Task Force was or wasn't around. But the timing looked good, frankly, as I wrote to Mr. Hilton, because typically around the holidays, the Christmas holidays and what have you, we have a typical waning of treatment interest amongst the population. It's historical, it happens every year.

The reason it happens is multifold. They're depressed, they're not home for the holidays, all their interest

wanes, okay. So my therapy participation generally around that period of time drops off. In discussing it with Ms. Rogers and Mr. Sager, it just seemed to us at a good time to try and go ahead and implement it because we would be in a slow-down period anyway throughout the institution. I wouldn't be impacting on that much therapy.

The issue personally with me, and what I was thinking about primarily at the time, was, all right, this is a quiet time to do it. I'm not going to get all kinds of complaints about the inmates not getting therapy. We can make this transition and hopefully make it smoothly, and we'll get through it without lawsuits from inmates saying, "They took away my therapy." Frankly, Assemblyman, that was what my primarily thinking was at the time, and that was our reason for going ahead at the time. In retrospect, there may have been some other things I should have been thinking of.

ASSEMBLYMAN MALONE: Did you yourself have communications back and forth with the Commissioner on this or through intermediaries?

MR. PLANTIER: Personally with the Commissioner, no. I had dialogue with the Chief of Staff Hilton, who was his assistant, and my correspondents went to Mr. Hilton. I had no idea when I was going to get it back, and I got a letter back from the Commissioner to go. He has told me at this point in writing that I am to report to him every 90 days for the foreseeable on how this is going. That means that I will have to be generating a report in about another 60 days.

MR. SAGER: I could shed a little bit of more light just for a second. One of the recommendations that Dr. Steele gave us was for us to form small subcommittees to work through the problems that would have to be worked through before the changeover took place. So one of the reasons why there was a time period between when her report came to us and when we actually did it was we were doing those subcommittees and

working through the details of the changes. I think that probably the time thing was more due to that than anything else.

SENATOR BASSANO: We thank you for--

DR. GRAFFIN: Could I just clarify something? Two issues that Assemblyman Mikulak had addressed before that I had wanted to give some additional information. You had asked about inmates not assigned to groups, and I had told you that we had asked the therapists to cross check that. There is also a staff member under the supervision of Ms. Rogers who is also doing a cross check on the entire inmate population to assure that all inmates are assigned to at least one group at this time.

The other issue that I wanted to go back to was you had asked if therapists were told that they could maintain their caseloads. What they were told was -- when the announcement was made that the program would be stopping around the holidays -- was that they should terminate with all their men assuming that they probably wouldn't be able to continue working with them. But, if there were men on their caseloads that for clinical reasons they felt they should continue with, we would try to accommodate that within security concerns that have to be managed.

ASSEMBLYMAN MIKULAK: But, you see, I had toured that facility in the late '70s early '80s, and it was run -- at the time I was led to believe -- it was run like a therapeutic community; of course the population was about 400. So, when I come back on a tour with the Legislature in 1994, I see a lot of people laying around. There's a big difference. I think the institution -- I'm not placing blame on you people -- lost it's goal, lost it's mission somewhere along the way; and that's what we're here to do, to refocus it.

MR. PLANTIER: Assemblyman, when I had 300 inmates -- around 1980 -- 300 inmates, it was a lot easier finding meaningful jobs. It was a lot easier to run the program as a

whole; with numbers become other problems. Again, I would just like to point out while this Task Force is evaluating Avenel, if you were to walk into Rahway or any other correctional institution--

ASSEMBLYMAN MIKULAK: No, thank you.

MR. PLANTIER: --with the numbers that we have now, you're going to see that is just rampant.

ASSEMBLYMAN MIKULAK: We'll do Rahway, next.

MR. PLANTIER: Now you're taking on something.

SENATOR BASSANO: Thank you for being here. The Task Force is going to break for lunch. We will be back promptly at 2:00 p.m. There are some sandwiches back there. If you have any telephone calls or anything you have to make, do it in that short period.

(RECESS)

AFTER RECESS:

SENATOR BASSANO: We will resume.

The next group of people we are going to hear from are ADTC staff. Some of them have asked that their names not be used, and I've agreed to keep their identify private, but I do want to hear from them. One person who is willing to have her name used is Dr. Kay Jackson. Kay, why don't you come up here and bring some of your folks up.

K A Y E. J A C K S O N, Ph.D.: An ADTC staff member will also speak with me at the same time if that's okay with you.

SENATOR BASSANO: That's fine.

Good afternoon, thank you for being here.

DR. JACKSON: Good afternoon, sir.

SENATOR BASSANO: Thank you for being here.

A D T C S T A F F M E M B E R: I'd like to pass some things out to the Task Force first.

SENATOR BASSANO: I don't think they want pictures taken, am I correct?

ADTC STAFF MEMBER: That's correct.

DR. JACKSON: I don't really care one way or another but--

An ADTC staff member, would you prefer--

ADTC STAFF MEMBER: Okay, I guess I'll speak first. I'm a Ph. D. psychologist. I'm in private practice in Freehold, N.J. I hold licenses to practice psychology in the State of New Jersey and the State of Pennsylvania. I've worked in corrections as specifically, as a forensic psychologist since 1982. I also do consulting work for the Division of Youth and Family Services, where I run a treatment group for juvenile sex offenders.

I'd like to talk to the Commission about what's broken at Avenel and how I think it could be fixed and what I think this body could do in terms of making recommendations that would help with that.

The first issue to be clear about, I think, is the nature of treatment for this population. In much of what you read or hear in the media, treatment is discussed as what happened during incarceration. If the offender behaves well during his treatment, then he can earn the privilege of being released early to resume his life in the community on parole.

The problem with this model of treatment is that it does not reflect what we know about change and how change really occurs. In fact, treatment is at least a two-stage process. Broadly speaking, the first stage involves recognizing a need for change and undergoing a planned series of interventions to bring about the needed changes.

The second stage involves applying what has been learned and maintaining the changes in the offender's home community. What's critical to understand here is that the

factors that influence the first stage are different from the factors that affect the second.

Now one implication of this is that it is counterproductive to assume that offenders can maintain the changes made during stage one without very specific supports during stage two. Moreover, the recidivism for sex offenders appears to be as much a function of failure at stage two as at stage one.

Now, let me make this a little more concrete. In other words, maintenance of stage one changes in the community is critical to reducing recidivism. The first implication of this view is that the sentencing structure for sex offenders needs to be changed. At present, we sentence sex offenders to determinate sentences with the option of parole if they meet our criteria for early release. That's the one stage model of treatment. We bring them in, we treat them, and we parole them. What we need is a sentencing structure that reflects accurately the two-stage nature of treatment.

Specifically, there should be a mandatory indeterminate, inpatient sentence, followed by a mandatory outpatient sentence. Every sex offender in this State should be sentenced under these provisions. This two-stage sentencing procedure would reflect the fact, which is well-accepted among those of us who treat this population, that sex offenders are not cured by inpatient treatment, but that many can successfully maintain the changes they have made when given adequate aftercare services upon return to the community. Thus, there would be treatment interventions during both stages one and two.

The first recommendation leads to the second; that is, improved outpatient supervision. One major drawback to the current parole supervision of sex offenders is that parole officers, generally, have no knowledge of sex offender pathology or how to spot it. Sex offenders usually look like very good parolees compared to other types of offenders; that is, they

report regularly, they find employment, and they appear to stay out of trouble. Consequently, parole officers are not very good at recognizing when sex offenders are starting to lapse; that is fall back into their old patterns that can lead to reoffending.

This problem could be remedied by making aftercare treatment mandatory with providers who are familiar with sex offender pathology. The providers could evaluate the offenders progress periodically and report to the parole officers, thereby relieving the P.O.s of a task for which they are not trained or experienced in the first place. A corollary to this is to make violation of the outpatient sentence and return to inpatient or incarcerated status a requirement whenever the outpatient providers recognize that the offenders are close to relapsing or have stopped complying with aftercare treatment.

A third recommendation is to stop assuming that all sex offenders are alike in terms of their potential for recidivism. We have fairly good research data now that indicate differential recidivism rates for different sex offender groups. Specifically, pedophile and rapists recidivate at higher rates than incest fathers. Homosexual pedophile appear to recidivate at higher rates than the other two offender groups.

Granted this, the outpatient sentence regulations, would need to be tailored to fit the differential reoffense risk for each offender group. For example, lifetime registration for many incest fathers is probably an unnecessary expenditure of money and energy, since incest fathers exclusively attracted to their own children do not pose a risk to the communities where they live, and they tend to stop being a risk to their own children as the children mature.

On the other hand, pedophile and rapists of adults do pose a threat to their communities and registration might help in tracking them depending on how it was set up.

SENATOR BASSANO: Just registration, you think, still would be necessary, even if you have people that are paroled,

that you're keeping track of them through the parole system?

ADTC STAFF MEMBER: That would depend on how it was set up, Senator. I mean, I think that certainly the tracking through the parole system is your first line of defense.

SENATOR BASSANO: If we had a system that paroled people and that required them to get into some type of community help program that we made available, and reports are continuously flowing back to Avenel and to the parole officer on the individual, you think that registration is still necessary?

ADTC STAFF MEMBER: Under those conditions, I would say probably not, probably not. But that would be contingent upon everybody being on parole, in effect, all sex offenders who come out of prison.

SENATOR BASSANO: Well, I think that if we sent up a system whereby you sentence someone to an indeterminate amount of time, the only way that they get out of Avenel is through parole, and if they do their time -- let's assume it's 30 years -- and the psychiatrists and psychologists at Avenel still feel that these people are potentially dangerous, you still have civil commitment. So they are never going to get out, except on parole.

ADTC STAFF MEMBER: That's what I'm proposing.

SENATOR BASSANO: As Senator Girgenti mentioned earlier, he has legislation in for lifetime parole, and maybe we would narrow that a little bit and have lifetime parole just for folks who commit these types of crimes.

ADTC STAFF MEMBER: That's exactly what I'm proposing. In other words--

SENATOR BASSANO: So there's your registration.

ADTC STAFF MEMBER: Yes, I agree.

SENATOR BASSANO: I interrupted you, I apologize.

ADTC STAFF MEMBER: That's okay.

SENATOR BASSANO: Please continue.

ADTC STAFF MEMBER: I also want to talk about something else that's broken, and what that is, is locating a treatment program within the Department of Corrections, without special safeguards. The problems that we're having at Avenel could have been predicted 25 years ago, when the decision was made to locate the treatment program in the Department of Corrections with no special safeguards.

What do I mean by that? The philosophy of the Department of Corrections is custody and control. A perfectly legitimate set of issues that need to be attended to for many of the people who are incarcerated. However, the philosophy of a treatment center is treatment, and what has happened over the years, and it's predictable, is that the influence of custody and control has become much greater than the influence of a focus on treatment.

Now, if you want to locate a treatment center within the Department of Corrections, you have to protect it. I have a couple of suggestions about how that might be done. One is to separate the budget process for this institution, for Avenel, from the rest of the Department of Corrections. Now, I'm a clinician, so I don't know how you do that. But let me just tell you what I think is needed.

When our superintendent goes to superintendent meetings, he's sitting around a table like this with a group of peers, other superintendents, who are interested in fighting for their part of the budget pie. He's the only superintendent who's there fighting for treatment money, okay, and there are more of them than there of him. The results are rather clear: we have a $29 million budget with $2 million allocated for treatment, not much.

So what's needed is some way to protect the budget of Avenel.

SENATOR BASSANO: Sir, even before that, one of the problems that I have had in trying to deal with this issue is

that I have two conflicting groups, if you will. I have the people who are administering treatment on one end and people on the other end who are running an institution. A decision has to be made as to which one has final authority. I have a real difficult time as to how you do that, in that type of environment, granted it's a jail. People are there because they are incarcerated, because they have committed a crime.

But some of the things that we've seen become counterproductive, such as a person being reprimanded for a particular infraction of a rule and then being denied to go to therapy when they are there specifically to go to therapy. How do you deal with that type of situation? I mean, it's counterproductive, if you will. Somebody has to be the final authority. For the life of myself, I cannot come up with a recommendation to this group as to how you do that. One of the thoughts is, maybe we ought to separate the two. Separate the two by saying that Department of Corrections runs the institution, but take the therapy out of Corrections and place it somewhere else for another agency to handle, maybe Human Services.

ADTC STAFF MEMBER: I think that would be worse, based on my experience with Human Services.

SENATOR BASSANO: Okay, that's why we throw these things out. But you see where the problem is, as to who has paramount decision-making power.

ADTC STAFF MEMBER: Well, I can tell you that there's been a shift in that, in that balance over the years.

SENATOR MATHEUSSEN: Chairman, could I interrupt for a second to ask a question?

SENATOR BASSANO: This is a small enough group that if we interrupt you, I apologize. But go ahead, Joe.

SENATOR MATHEUSSEN: Why? Why would that be worse?

ADTC STAFF MEMBER: Department of Human Services?

SENATOR MATHEUSSEN: Yes.

ADTC STAFF MEMBER: Because they can't administer anything.

ASSEMBLYWOMAN WRIGHT: Exactly, and it's a two-masters concept.

ADTC STAFF MEMBER: They're a joke.

SENATOR MATHEUSSEN: Well, if not Human Services, then do you agree that somebody else should run it?

ADTC STAFF MEMBER: You've also cut, under Governor Whitman's proposals at least, there are going to be further cuts in the Department of Human Services, so adding further--

SENATOR MATHEUSSEN: But not in the area of--

ASSEMBLYMAN MIKULAK: So far, you're talking about Medicaid.

SENATOR MATHEUSSEN: We're talking about Medicaid cuts, we're not talking about cuts for--

SENATOR BASSANO: I think when this report goes out then we'll--

ADTC STAFF MEMBER: Okay, as I said I'm a not a legislator, I'm a psychologist, so I may have my facts wrong.

SENATOR MATHEUSSEN: We have to vote on the budget, so it's our responsibility to make sure we understand where the cuts are, and unfortunately, they are not always reported in a very detailed sense, only in a generic sense.

But, nonetheless, would there be another department that would be better to oversee than Corrections, the therapy part?

ADTC STAFF MEMBER: I don't really know whether there would or not. Again, I think, regardless of where you put this institution, you have got to institute some special safeguards to protect it, to protect it's treatment mandate.

SENATOR BASSANO: I think that one of the ways that we do that-- It's been suggested that we look at a permanent commission to oversee the institution, made up of, maybe, a couple legislators and public members, that will meet

periodically to make sure that the dollars that are flowing to Corrections which then have to flow back to Avenel be monitored properly.

One of the problems that the Governor pointed out in her budget, was a very interesting statistic, when she said that we spend the third highest amount of money for education, but we're 48th in the money getting back to the classroom. Same thing could be said here, that we're appropriating the money, and if they're going to put more prison guards on, that's not going to solve our problem of treatment. Therefore, if there is a commission looking over the shoulder of the institution, maybe someone can get to someone's attention in the event this doesn't happen and that the dollars do flow back properly, but that's another suggestion.

ADTC STAFF MEMBER: I think that's an excellent idea. My only caution about that would be to make sure that this is a real commission and not a rubber stamp. If you appointed--

SENATOR BASSANO: I understand.

ADTC STAFF MEMBER: --a watchdog commission, because, you know, the government has too many rubber stamp organizations.

SENATOR BASSANO: And commissions that don't meet.

ADTC STAFF MEMBER: Yes.

SENATOR BASSANO: In this case, I think we're dealing the public's safeguard, and I think that commission then becomes important.

ADTC STAFF MEMBER: I would also recommend that if you set up a commission like that, that you make sure that you have some -- had some treating professionals on the commission who work specifically with this population, not just any psychiatrist or any psychologist, but people who know this population, who work with it.

SENATOR BASSANO: The doctor who testified earlier this morning volunteered already to serve on it. I mean, she

has a background in the area, but people of that type that have an interest in making sure that treatment is done properly.

ADTC STAFF MEMBER: Well, I think that would be a step in the right direction.

SENATOR BASSANO: Mr. Thomas also already volunteered for something of that type if it ever came about.

ADTC STAFF MEMBER: Let me go on here in terms of things that are broke that need fixing. Another problem with locating the ADTC within the Department of Corrections is that hiring is tied to the Civil Service System.

SENATOR BASSANO: We'd like to get rid of that. That is going to be one of my recommendations.

ADTC STAFF MEMBER: I'm very glad to hear that, because we have to hire, when we hire psychologists, social workers, teachers, and corrections officers, we have to use the same, as you know, the same civil service list as every other penal institution. And when Avenel opened, there were very few people in the world who had any experience and any training in the treatment of sex offenders, that's not true now. There's been a real explosion in the last 10 years in workshops, and conferences, and opportunities for professionals to learn the skills of sex-offender-specific treatment. And there are people out there now -- I was almost able to hire two of them when I was the director of psychology, got one of them, one out of two isn't bad -- who have that training and that background. Those are the people we should be interesting to come to Avenel. We should be encouraging them, but if you do and they are not on a civil service list, you can't hire them anyway, and even if they are on the civil service list, if they're not towards the top, you still can't hire them.

SENATOR BASSANO: I think one of the things that some people may want to do is maybe work a day or two at Avenel and still work in a private practice. You may want to encourage that sort of thing without civil service.

The other thing a commission would do would be to make sure that these people are going to be paid properly, because if you're going to skimp in the area of paying people who are well-qualified, you're not going to get the well-qualified.

That's another concern that I think we have to address. Because I think that's one of the things that I'm being told that's happening now. That we're getting people who can't get a job anyplace else, that are now applying for Avenel in some cases. I say in some cases, not all cases.

ADTC STAFF MEMBER: Yes, let me address the point that you just made. The other problem with the Civil Service System, as it now stands, is that administrators do not have enough time to evaluate a new candidate's performance before that person becomes permanent, the way the Civil Service System is set up. So you don't have a very good sample of the person's behavior and now they're permanent. You can't -- it's very difficult to fire anybody once they're permanent, as you know. It's also difficult to assign them for retraining. It's also difficult to, oftentimes, to supervise them once they're permanent.

SENATOR BASSANO: When we're talking about reassigning, we're talking about some of the other things that you're mentioning: the power to do that should be left with the director of treatmen, whoever that may be. That should not be left with the superintendent running the institution, am I correct? That's what you would envision?

ADTC STAFF MEMBER: I think that would be good, yes.

SENATOR BASSANO: You don't want the superintendent running the institution making those decisions?

ADTC STAFF MEMBER: No, the person who's making those decisions should be someone who has a background and experience in treatment, per se.

SENATOR BASSANO: Legislation that I wrote--

ADTC STAFF MEMBER: It could be, the-- In fact, it could be-- No, I am not quite saying that. It needs to be a person who has a background and experience in treatment issues.

SENATOR BASSANO: Legislation that I wrote called for the top person doing the administration of any program in Avenel to be a psychiatrist with an M.D. degree, starting at that level and then coming down pyramiding.

ADTC STAFF MEMBER: How many psychiatrists do you know who are heads of hospitals?

SENATOR BASSANO: Go ahead.

ADTC STAFF MEMBER: I don't think that's a good suggestion.

SENATOR BASSANO: Okay.

ADTC STAFF MEMBER: I think what's needed, if this is going to be a institution focused on treatment, a treatment center, is an administrator with background and experience in administrating treatment centers. You get a degree in hospital administration, oftentimes. Now, in this particular situation, let me say in this particular situation, you have a man here who has devoted his entire career at this institution. He knows the institution inside and out. I don't always agree with the decisions he makes, but he's experienced. And you would be very foolish, very foolish to just assume that because he's not an M.D. or a psychiatrist or a psychologist that he's not doing a competent job and doesn't have the skills.

What I do think is that just like me, in order to keep my skills up, I have to go to training workshops and conferences. I think it would be good if administrators had the same opportunities.

Which brings me to the next point which is there is no money for training, at this point. There is no money for sending people to conferences; we do it all on our own when we go. That's another safeguard that needs to be put in. In the budget line for Avenel, there needs to be a set amount -- and

I'm talking $20,000 - $30,000 a year -- for staff training, okay. You can't expect people to keep up with the field without it.

SENATOR BASSANO: Even the Legislature does that.

ASSEMBLYMAN MIKULAK: I alluded to that before. When there's a budget in Corrections which is close to $600 million, and all we see are the requests and what's approved for the institution, and the request is approved every year, we don't see those problems at that level.

SENATOR BASSANO: You don't see the fine line items, if you will, as to how that $600 million is broken down. It goes to the Department, and they, in many cases, allocate to different areas, unless we specifically do it legislatively, it becomes difficult. Or we have someone like Peter Inverso who is interested in this subject and is on the Appropriations Committee to make sure it gets back to where it's supposed to.

SENATOR INVERSO: I have my checkbook with me, right now. (laughter) I'll take care of this for you.

ASSEMBLYMAN MIKULAK: Assemblyman Malone is on our Appropriations.

SENATOR INVERSO: Mr. Chairman, you've given me an opportunity here. I'm somewhat troubled -- and the Committee that I Chair does get involved with civil service matters -- I'm somewhat troubled though that we have to have Civil Service Classifications for this type of professional. I think, going forward, it ought to be one where we contract with the professional. Therefore, the training that you allude to, while it may be necessary for lower staff echelon, but when you're getting into the category of, you know, the therapist, the clinician, I think we hamstring ourselves by putting these positions under a civil service guise. Obviously, your comments are right on target. I think that one of the things that we have to look toward, going forward, is Statewide, in terms of

all our professional classifications, as to whether we need to perpetuate a system where they become employees of the State.

ADTC STAFF MEMBER: Well, it subjects people to a whole other set of forces, which are really counter to doing a quality job.

SENATOR INVERSO: I'm sure it's frustrating. I'm sure there's a thwarting effect by having that in place, in terms of the professionalism.

ADTC STAFF MEMBER: You're quite right.

SENATOR INVERSO: I will make a point of that and discuss this point further.

SENATOR BASSANO: Please continue.

ADTC STAFF MEMBER: Another thing that's broken that needs fixing is money for research. The woman sitting next to me, Dr. Jackson, has been the appointed Supervisor of Research at Avenel for almost five years now. She carries a caseload which is huge and still tries to find time to carve out to do some research. That doesn't make any sense.

We need a position, that budgeted at a reasonable level, to allow some person to coordinate research at Avenel and gather data on recidivism. I think it's absurd that our last recidivism study was done in 1988. That's crazy, okay. But it's not our fault, folks. The Department of Corrections doesn't keep data recidivism, officially.

SENATOR BASSANO: I think this Task Force will mandate that be done in our report.

ADTC STAFF MEMBER: That would be great, but you have got to give us the money to do a quality job for you.

SENATOR BASSANO: I think when you mandate something, the Legislature is kind of, almost, forced to give you the dollars. I don't think that it's that expensive a program to do, and yet we have no idea as to where we are without those figures. I mean, it's all a guesstimate at that point--

ADTC STAFF MEMBER: That's right.

SENATOR BASSANO: --whether we're succeeding or not.

ADTC STAFF MEMBER: That's right. I hope, too, that that budget line will be a permanent one, so that ongoing research can take place. Because as a clinician, I can tell you that there's a lot of good information about which techniques work with which populations that I would be really interested in, but that's the kind of basic research that needs to be done on an ongoing basis. It's not just a matter of doing a recidivism study and saying, "Okay, this is our recidivism rate for the last five years." It's also an issue of evaluating the treatment techniques that are being used, that were being used, that we're bringing on line to see how effective they are in the institution.

SENATOR BASSANO: You would also be evaluating recommendations that the Legislature will be making in this report to see if what we're suggesting, insofar as incarcerating those people who we feel can't be helped, helping those people who want to be helped, as to what type of ratio we're going to develop. That's important, because then you know your success -- where you succeed and where you're failing.

ADTC STAFF MEMBER: The other thing I'd like to say about what is broke and needs fixing is corrections officers. In order to have a therapeutic milieu, a milieu that is positive to treatment, everybody who works in that milieu needs to support the goals of treatment. That's not what we have.

At the present time we have corrections officers who are trained at the Corrections Officers Training Academy who get a little bit of orientation to the treatment of sex offenders because Mr. Sager goes to the Corrections Officers Training Academy and does a presentation. Then some of those men come to our place. Most of them think that sex offenders are complete scumbags and probably should be shot or have other things done to them that I won't mention here. Many of them take rather a

delight in baiting people and in making -- in punishing them all over again, is really what it boils down to.

A person has a right to feel that way. I feel that way sometimes when I read the histories of the guys that I treat. But I don't think it makes any sense to have people with those attitudes working in a treatment center. What they do is poison the atmosphere.

We have men in group who we are teaching to manage their anger, to behave in socially appropriate ways. They come out of group, go back to their wing and have to deal with abusive, angry, belittling corrections staff. It doesn't make any sense.

I think the way to remedy this is to have a special hiring procedure for corrections officers who work at Avenel, as well. Number one, I think we should hire, if we can, only hire individuals who are interested in working in such an environment, and not every prison guard is. That's fine.

SENATOR BASSANO: A lot of them are, because it's considered a plush job in comparison to Rahway.

ADTC STAFF MEMBER: Yes, yes. But they need to know that if they come that they are going to be much more involved in the treatment team. They are going to be interacting with psychologists; they are going to be interacting with social workers; they are going to be interacting with inmates in a different kind of milieu. Then we need to evaluate the people, the corrections officers who apply to work at Avenel, to make sure that they don't have serious personality problems. We can do that; we're an institution of psychologists, okay, we could do that. And then, we need to keep tabs on them, and the bad apples who show up need to be transferred. That would go a long way to changing the atmosphere at Avenel.

I think that's about all I want to say about what's broke and what needs fixing. I'd just like to conclude by saying that the name of this institution is The Adult Diagnostic

and Treatment Center. It's not the Avenel Prison, and I think we need to return the institution to its original mission, or we need to lock up all the sex offenders in this State forever. Those are really the two choices that I think we have.

DR. JACKSON: I would also like to pass out some materials. What I've enclosed here: an article regarding the cost-effectiveness of treating sexual offenders, a copy of my vita, and a copy of a proposal regarding recidivism and a study. What you see there is a variable list that I've compiled along with a number of other experts, and it constitutes a wish list in that it requires quite a bit of time to be able to find all those variables. So that's something that is a variable list that I'd like to see used when and if we are able to conduct a meaningful recidivism study.

What I have passed around to you are Xeroxes that I've made available. I hope I made enough copies. What I would like to give to now, however, is a packet which I have not been able to Xerox for everyone. I will turn this over to you, Senator Bassano and Assemblyman Mikulak. This is a stack of Xeroxed letters sent to us--

ASSEMBLYMAN MIKULAK: I brought some with me that I got in the last few days. A lot of cc:s to Kay Jackson.

DR. JACKSON: A lot of cc:s to Kay Jackson, it's true. I am the disgruntled current employee, rather than the disgruntled former employee as many other people are referred to, who is quite concerned about the programmatic changes that we have been affecting. When I originally volunteered to address the Task Force, it was my hope that I would be able to talk to you about such factors as research, our hopes for the future, the possibilities of the transitional housing program proposal that has also been circulated to you, developed by a group of inmates. Unfortunately, today I find myself in the position of asking you to consider interceding in what has turned into a rapidly escalating problem.

Perhaps the most interesting aspect of our treatment program prior to Monday was the fact that we managed to have a participation rate of 700 out of 750 men.

Yes, I know, I'm running out of batteries, all right. (referring to low battery warning alarm on personal computer)

At this point, I think that it is impossible, contrary to what the administration suggested this morning, to be able to know how many men will refuse to participate now as a result of our programmatic changes. Unlike, again, what the administration suggested this morning, as of Monday afternoon, a substantial number of inmates were assigned to absolutely no group whatsoever. At this point I had, as of Monday, originally, 82 inmates that I saw on a weekly basis on in-patient therapy groups. I also see an additional, between 15 and 20 men on a weekly basis in aftercare. Of the 82 inmates who were attending groups, for 81 of them, this programmatic change which has been represented as something that will increase therapeutic participation has resulted for 81 of them in a reduction of sheer number of hours that they voluntarily come to treatment.

I wanted to make that clear. This is not a group that I have to prod or pull by the hand. I have a waiting list of 20 men who have asked to come to group with me, personally. I have had very little difficulty getting between a 90 percent and 100 percent attendance rate. I do not have difficulty persuading people to come to treatment.

I deal with a number of inmates who are on the more disordered end of the spectrum, as a previous witness had mentioned, people who are rapists, people who have lengthy criminal histories, people who have lengthy nonsexual criminal histories. That's my population.

Unlike William Pither's program in Vermont, which deals with a handpicked and very select group of offenders who we can all predict will do very well in virtually any kind of

treatment facility, this treatment program works with people who are mandated to come for treatment who are not intrinsically motivated when they arrive at the facility. So the fact that they do come and they do participate is a very important statement.

Most of the people who I work with are serving what we would refer to as heavy time. They will be with us for a long time. They have been with us for a long time. Though I cannot offer you any numbers regarding recidivism in general, I am very pleased to report my own personal recidivism rate. I have released 54 inmates, either through max out or through parole, and out of those 54, four men have reoffended. That suggests that I have somewhere on a 90 percent to 92 percent effectiveness rate. I have been at Avenel for 10 years, and I am very pleased to be able to stick by those numbers.

I also would like to suggest that when I am concerned and expressing concern about the programmatic changes that we are making, I am not doing so from the position of merely being negativistic. My original purpose in working with the Programmatic Revision Committee, and in fact, starting it, was to be able to do some self-study and to implement some other psychoeducational modules that we thought needed to be in place to explore how we could prevent staff burnout. When I started working at Avenel I had a caseload of 32. As I mentioned, I had that mushroom to 82, and I am one of the people who has had a protected caseload as a result of my involvement in research. So I have some difficulty thinking that this programmatic change is going to be effective when it results in a sheer reduction for the vast majority of the men that I work with in available groups.

The people that I am working with are representing their views in those documents. They are asking you to consider forcing the administration to live up to promises that they made to the treatment staff and that they made to the inmate

population; that is, specifically, when we were told in December that we would be assigned to wings -- to work on wing units -- we were told that we could transfer our cases with us if we needed to keep them with us.

When I submitted a list of the people that I wanted to continue to work with, since I did not have a major problem with any members of my caseload, I was told that I am overinvested in my cases. I am more than slightly offended by this. It seems to me that it is very difficult to try to determine what constitutes overinvestment and what constitutes sufficient investment to do a good job.

Some people here have asked how you know when somebody is ready for release and what kind of criterion we use. One of the criterion that I use is a very personal one. I was held hostage at the ADTC when I was pregnant, so certainly that has made me quite sensitive to issues of safety and concern to the community. When I participate in releasing an offender, I do so with the knowledge, as a parent of two children and as a female, that he could be going into my backyard. I do not try to move away from those kinds of issues.

At the same time, I don't believe that it is useful to have people serving sentences with absolutely no hope of parole. At this point, we have offenders who do not have family support. It is not possible for them to be able to secure parole because they only have placement settings available. So we are in the catch-22 position of preparing men for release into a community which now no longer welcomes them, tolerates them, or indeed, has a place for them.

The Parole Board is certainly much concerned with these kinds of issues and has rejected over the last year a number of men who therapeutically are ready for lack of a suitable parole plan. I also must say that when offenders present themselves to the Parole Board for parole release consideration, they are held personally responsible for the

extent of their therapeutic participation; that is, that the Parole Board asks them, directly, how frequently they go to group, asks them how much they avail themselves of the opportunities that are at Avenel.

If we have reduced those available opportunities dramatically, those inmates find themselves in a particular double bind. They are attending all the groups they are able to attend; nevertheless, their available groups represent a dramatic reduction in sheer contact with professionals. So I find this situation to be deeply troubling to me.

Finally, I must say that I am very pleased that the Senators and the Assemblypeople here have been able to receive a copy of Dr. Steele's report. I personally have not been able to do so.

ASSEMBLYMAN MIKULAK: We haven't either. They said that we did, but we really haven't gotten that. We're going to follow up on that.

DR. JACKSON: Dr. Steele and I spent a great deal of time together during the time that she was at the ADTC, and she expressed deep surprise to one of my colleagues when they met together in San Francisco at the Association for the Treatment of Sexual Aggressives at the fact that her report had not been disseminated to staff. On Monday, I requested of the Assistant Superintendent an opportunity to read this report, as I had been told I would be able to do. I was told to come downstairs at noon, and I would be able to see a copy of that report. When I showed up downstairs, I was told that I needed to make an appointment and that copies of that report are being held in either Mr. Sager's office or in Grace Roger's office, and I needed to set another appointment to come back at another time. I'm not sure what's in this inflammatory document, but I'm awfully curious.

I also must say that it is to my dismay that members of the treatment staff who have posed concerns and

dissatisfactions with the way that the programmatic changes are being implemented have been targeted, have been identified as being less than fully supportive. May I say that the idea for changing this program around was mine, in conjunction with the previous witness, at around the point that we got quite clear that it was an ethical dilemma for us to both be in the position of trying to assess somebody's readiness for release while at the same time treating them. This is an ethical dilemma that has been attested to by the American Psychological Association. I can give you another document, if you would like one, called "Who is the Client?" suggesting that it is improper for us to be in this position.

Now I find at the end of this programmatic change that I still have this same dilemma that caused me to originally suggest that we engage in this self-study and revision committee; that is, I'm still being asked to assess somebody's readiness for release. Only my caseload has been changed, so that years of knowledge of working with particular offenders is functionally lost.

I have been told that if I want to keep inmates with me and transfer them to different housing units, I may elect to take somewhere between 8 and 10 of my inmates with me. That suggests that out of a group of 82, since 10 happen to already be housed on the unit to which I have been assigned, that there will be somewhere on the order of 52 other men who will not be selected by me as a priority to be transferred to that unit. That represents a very substantial loss in sheer knowledge of who these people are.

I am not saying that no one else can do the job that I do with them. Certainly, they can. But I fail to understand how this is useful in terms of sheer cost-effectiveness. I have spent, in some cases, many years working with people. It would take me a very large amount of time to transfer that information

over to a colleague, and I do not understand why it would be advantageous to do so.

SENATOR BASSANO: The treatment that you give, do you believe that it is extensive?

DR. JACKSON: Do I believe that the treatment that I give is extensive?

SENATOR BASSANO: Yes, do you believe that you are giving your clients enough time, or do you think that people at Avenel need more than the amount of time that they are receiving right now?

DR. JACKSON: I have a somewhat unusual population relative to the overall Avenel population, which is composed of two-thirds pedophiles and incestuous fathers and one-third rapists. It is also two-thirds caucasian and one-third nonwhite. My caseload is almost two-thirds nonwhite and almost two-thirds rapist. So I do not say that my caseload is exactly representative. Of that population, most of these people I have worked with for a lengthy period of time. I get sort of the more hard-core offenders. I do not get people who have short time. That may very well be part of the reason why I believe I have been effective. Most of the people I work with have been incarcerated for a long time. They are very motivated to change.

Before the change happened, most of these people were in a number of groups, not just one treatment group a week. They were in a second opinion group, they were in a substance abuse group, they were, perhaps, in a self-help group, a parapro group. And I encourage them to be active in treatment. I think it's necessary to be quite active in order to achieve change. We're talking about people who took many, many years to become this disturbed.

SENATOR BASSANO: Talk to me about the halfway houses. Tell me where that fits into the program that we may recommend, how it would be helpful with paroling people, where it is

effective in other parts of the country if it's used, or where it is not effective.

DR. JACKSON: I am not an expert on halfway houses or their success rate. I was somewhat facilitative with this particular group of people when they wanted to be able to advocate for doing this.

From my perspective, one of the advantages of dealing with a halfway house would be, first of all, that if someone fails to abide by the rules of a halfway house, they simply get returned to maximum security -- prison. If we do that well, they are on a parole status. It is quite a simple matter to return them back inside the facility if they begin to show signs that they are lapsing. That is possibly the most significant reason.

The second reason is that it would facilitate for parole officers being able to evaluate their behavior because they're locked in a particular facility, they're housed together.

ASSEMBLYMAN MIKULAK: Under the new regime that has been instituted -- that they are in the process of instituting -- a case manager, what's the function of a case manager? How should that work?

DR. JACKSON: I will try to answer that as noncynically as possible. The function of a case manager at this point is to write a routine review. Routine reviews are written every six months. A case manager will now accrue information from a variety of sources, which I think is a very good idea. A case manager may find information from an individual's housing officer, from his work supervisor, from the therapist or social worker who ran a module during that time period, and accrue all that information together and write a report about that. I think that that is a very good idea.

However, given the fact that some of the case managers are dealing with -- indeed, all of us are dealing with caseloads

now with which we are predominantly unfamiliar, I have some difficulty imagining how we will go about doing that.

ASSEMBLYMAN MIKULAK: What's the level of training? Is that like a social worker?

DR. JACKSON: No, now we have all been made case managers. I also would add that, at the risk of seeming impudent, this Commission is not the only body that has not been apprised of the therapeutic changes that were going to take place in this program. The Housing Committee also was not apprised of these changes and was quite substantially alarmed as a result of it. Officers within the facility are confused. They have difficulty knowing where to refer emergency cases. New inmates who have not been assigned any therapists yet, of which we have a number, do not know who to turn to. So it is posing quite a substantial dilemma, and it is not a programmatic revision that is enjoying the level of support that it really could. The fact is that there are some very good ideas in this. I think it is very important that we cut back the waiting list that we had. We had a waiting list that would last two to three years to get into modules that were important for them to be in. So I think it's important that we cut back that waiting list. I just don't think that any of us thought that it would occur in this way.

SENATOR BASSANO: Senator Inverso has a question.

SENATOR INVERSO: Yes. I made a note when the superintendent was here, where he indicated that the changes were not, in his words, significant. The other notation I have is--

DR. JACKSON: Shall I move for the lightening bolt? (laughter)

SENATOR INVERSO: Well, this is verbatim. Also, the paragraph: "We have reviewed our proposed changes with both the inmate committee and the population as a whole," which was the

subject of some discussion this morning, "and have met with generally favorable responses."

Again, I'm not looking for you to refute the factualness of this, but if this is so, how is it that someone in the position that you occupy was not, in a sense, in the loop relative to the changes?

DR. JACKSON: I can answer that in a couple of different ways. I dropped off of the Revision Committee when I believed that it had really taken hold and had moved in a direction that made good sense. Clearly some changes were going to continue to be discussed. I had reached out to Dr. McCafflin (phonetic spelling) from the Special Classification Review Board and had arranged to meet with her a number of times. We had talked about the importance of assessment, particularly when an offender first entered the institution.

After that I began to work a little bit more closely on various research projects, and it is true that in December a number of us, though reluctantly, said, "Well, we will try to comply with the administration's desire to implement these changes at this time." But we were given assurances of the capacity to maintain our caseloads. That is the singular and most substantial distortion that has occurred. In custody, one of the difficulties is that a seemingly simple administrative decision can have profound effects.

For example, in December also, the administration at the ADTC made what would, I'm sure, sound like a very simple decision that has resulted, again, in another dramatic reduction in the availability of contact between therapists or social workers and inmates; that is, two times a day during working hours of our facility, between 11:00 and 12:00 and between 3:30 and 4:30 we have what is called a count. That is an institutional count and all inmates must be accounted for at those times.

Because too many of us were trying to actually have contact with inmates during those hours, the administration decided that rather than having the officers be able to report when inmates were meeting with the therapists, which had not been a problem for the preceding decade that I knew of, the administration decided that this was a bad idea, and we are no longer allowed to do that.

That means that for 17 of us who are therapists, there are 35 potential contact hours a day with inmates that are eradicated immediately. It does not include the other five social workers who also see inmates. That does not include any of the other people who also have contact with inmates during those times.

I must say that this occurs at a point where we still have difficulty hiring staff, and we do not have substantial coverage.

SENATOR INVERSO: So you've lessened the contact opportunity because of that, which heretofore had occurred even though the counts were being taken. They were accounted for by--

DR. JACKSON: Without incident. And without incident.

SENATOR INVERSO: I could understand as a layperson the need for the ongoing interaction and rapport you've established from a technical standpoint or a therapeutic standpoint, with your patients; therefore, in any transition the importance of retaining that group with the therapist, with the professional-- Other than that, if there could be a transitional period where someone like you could maintain that core group that they were working with, until such time as that core group changes, will the program work?

DR. JACKSON: It would certainly go a long way toward making a transition a much more smooth thing, absolutely. However--

SENATOR INVERSO: So your principle objection is that this break in the continuity that should exist, which I recognize is probably an important issue, but if that were to be addressed and resolved, the implementation of these program changes, do they make sense to you as a clinician?

DR. JACKSON: Yes and no. Again, I have some difficulty, even if we were able to segue more effectively without this dramatic loss of knowledge of who these people are and how they function. If we have made changes that have resulted in a reduction of available groups, then we've done something wrong.

ASSEMBLYMAN MIKULAK: What do you think--

SENATOR INVERSO: But we don't know for certain, at this point?

DR. JACKSON: Well, I know that the sheer number of groups that are up and running has been reduced -- absolutely, guaranteed.

SENATOR BASSANO: Can we hold the two of you here for further questions and bring up the gentleman in the back who does have to leave. So why don't you just sit there. I won't reveal--

DR. JACKSON: He actually has to leave, also.

ADTC STAFF MEMBER: I have to leave at 3:30.

DR. JACKSON: I don't.

SENATOR BASSANO: I won't reveal this gentleman's name; however, he does want to testify, and we want to give him that opportunity.

C R A I G L. C O N W A Y: Good afternoon. I will reveal my name. My name is Craig Conway. I'm a treatment staff member at ADTC. I'm passing around a copy of my written remarks because a lot of this stuff has kind of already been said, but I am passing around a copy of my written remarks in case anybody wants to refer back to them.

I have a master's degree in Counseling Psychology from Rider University. I'm currently a social worker at ADTC, and I am certified by the State Board of Social Work Examiners as a social worker. I also practice privately as a counselor and am awaiting for the license counselor for licensure in that.

I'm pretty dedicated to the field of sex offender treatment. I think I'm dedicated to my professional responsibilities to the State. I spend many of my own hours engaged in professional activities that relate to the workplace. I work many hours of overtime, and I don't spend much of my work time idle.

This is for good reason. Like I said before, I'm dedicated to the treatment of sex offenders because I was a victim of child sexual abuse myself. I'm also a resident of Hamilton Township, and I have a goddaughter who used to play with Megan Kanka. They live one backyard away from the Kankas.

I'm committed to the safety of the public, and I'm in favor of laws and treatment that are a means to achieving the end that no human being be subjected to the horrendous act suffered by Megan and the Kanka family. I don't feel that the recent legislation or the changes in the treatment program at ADTC will meet those ends though.

You've heard a lot about instances of mismanagement at ADTC, and I think that is one of the primary problems. Consequences of the correctional mismanagement of a treatment facility is the breakdown of effective treatment. Many programs that might be effective are squashed by an administration that does not understand the impact of their decisions. The ADTC is so top-heavy with administrative staff that I'm really surprised that it took this long for the facility to fall flat on its face.

Among this administrative staff there is not one person who is credentialed in the field of sex offender treatment -- the people who you saw sitting before you today --

except for Dr. Graffin, who I believe has been with us a total of two months. The staff members who are credentialed like Dr. Jackson are expected to work in a hostile environment. They are grossly underpaid, endure poor working conditions, and are overburdened by unmanageable caseloads. Further, they are supervised by staff that are unqualified to supervise them. This creates extremely low morale and assures that the staff's optimal performance level isn't reached.

The first change that I would say would need to occur is that the administration of the facility come from a treatment background so that philosophically the facility can be treatment oriented.

We're severely understaffed on the line. We need more Indians and a whole lot less chiefs. Obviously, for this to occur, positions that are meant to be filled on the front line, of which, Mr. Sager's position was fought for by the union, as a front line staff member, okay-- That money was taken and put into administration. Since I've been at the facility, Mr. Sager has never had a caseload, nor has he been qualified to do the assignments that he has been given to do. He was named top psychologist, and at the last check -- my last discussion with him -- he didn't qualify for even the lowest level psychologist in the facility, okay.

The facility's administration definitely needs to be monitored, and I'm glad to hear that the Commission is looking at a permanent level of monitoring so that funds that are designated for something are actually used for what they are designated for. When the Department hired Dr. Steele -- and this is kind of repeating what Kay said -- we've been kept in the dark, entirely, about Dr. Steele's report. All who I have talked to have spent a great deal of time with her. We agreed on a lot of treatment changes. The treatment changes that we talked about, though, we've kind of totally lost a third of

those changes in what was really slammed down our throats recently.

For whatever reason, instead of taking the parts of the program that weren't working and maintaining the parts that did, we just threw the baby out with the bathwater. The new program that was implemented this past Monday on a mandate from Superintendent Plantier is poorly organized. It lacks accountability, and in all likelihood will be a lot less effective than the inadequate program that previously existed.

We now have a program that was hastily slapped together to appease some mandate, that the likelihood of it having any effectiveness is sincerely questioned by anyone who has any knowledge about the treatment of sex offenders.

I personally worked this past weekend and reviewed 50 percent of my caseload, which comprised 15 percent of the institution. That would amount to, in real numbers, about 100 men. Forty of these men were not assigned any treatment at all. Another 20 of these men were assigned an hour and a half -- not a week -- per month. Per month they were assigned one group. Some of the cases, these guys used to attend 15 hours of therapy a week, and now they are in an hour and a half of class, which there is a big difference between class and a therapy program.

These types of problems, when they are articulated to the people who sat before you today, are written up. The staff members who do care enough to speak out are generally publicly humiliated in front of the rest of the staff -- in front of their colleagues.

Inmates and staff alike, we're all in a whirlwind, and we really don't know where to turn next. Nobody truly understands what this new treatment program is or how it was conceptualized. But I know for one, I worked on a lot of the treatment revision subcommittees, and this was not the way we conceptualized it. At least, it wasn't the way that I conceptualized it.

I think the new program was supposed to be designed to administer pretests and posttests to measure the effectiveness of each module as the superintendent alluded to earlier. Most of the modules that we did already start this week, did not have those pretests and posttests because they were never ordered. They were never budgeted for; they were never ordered. We don't have them.

The ones that do have pretests and posttests are pretests and posttests that were designed by institutional staff and with good intentions, but have never been tested for reliability or validity. So we don't know what they are measuring, okay.

ASSEMBLYMAN MIKULAK: We don't either.

MR. CONWAY: The programs currently in effect, I don't think, will do anything more, and in some cases, will actually do less to assess the program's effectiveness or the inmate's potential of risk upon release.

We are currently losing the value of therapeutic relationships between an inmate in treatment and his therapist by not continuing traditional therapy groups along with the modular program. They have continued something called process groups, of which on my particular caseload, only 10 percent of the inmates will be involved in. A process group would be a traditional therapy group where a guy really gets to work on his problem, rather than being a classroom type environment.

Some of the modules are definitely extremely needed, but I don't feel they will do anything to effect real change in the inmate if not paired with therapy that will foster integration of these concepts into his person. We need to be able to teach skills as well as measure the inmate's ability to integrate them and utilize them to control his behavior. As the previous witness said, there is no cure, but the best we can hope for is control if we're going to let these gentlemen walk the streets ever again.

We need to be able to motivate individuals into treatment, initially by externally rewarding them and then by moving to an internal system of reinforcing their behavior. We have intellectually challenged inmates at ADTC that have no programs available to them, no programs that are understandable to them. We have monolingual inmates that have no bilingual and bicultural psychologists to provide therapy for them. I think there are many, many changes that need to occur in order for the treatment program to be effective. To accomplish these changes I think a team of qualified treatment professionals needs to be allowed to take the time to make the changes, to have the decision-making authority to actually effect the changes, and to be allocated the resources needed to do so.

I think that currently we have laws that tend to reverse any rehabilitation that has occurred. From the perspective of what you all can do as the Legislature to facilitate changing this, I would suggest that a temporary injunction of some sort be placed on ADTC from continuing this barbaric treatment change. You know, let's slow down a minute and not jam this down people's throats before we really think about what we're doing. Allocate necessary resources; that is, to budget money directly to treatment and monitor of that money so it is actually used for hands-on treatment. Rescind laws that obviously create public hysteria and make it impossible for an individual to reintegrate into the community. That I'm sure is not going to be a popular one, but I think that these laws additionally create a false sense of security to the community. We're obviously not able to tell the community every person who is a sex offender.

I think that we need to establish laws that will provide for lifetime monitoring of sex offenders through registration, utilizing specialized borough offices that are qualified to assess an individual's needs in the community to control their behavior; provide resources for the aftercare

treatment of the individuals in the community upon their release, and establish a committee of qualified professionals to consistently monitor the accountability of the treatment program and the system.

I think that there needs to be a continual care for a sex offender, and I would definitely agree with -- I think the Senator left -- that there should be a punitive portion of the sentence. I would strongly suggest that that occur first.

So put him in State prison for a period of time. Then have mandatory in-patient treatment through indeterminate sentencing. We have indeterminate sentencing laws, and there is no reason we can't have a mandatory punitive sentence and then an indeterminate treatment sentence, followed by mandatory out-patient treatment in the community monitored by specialized parole officers and treatment professionals. I would strongly suggest that that would be lifetime for those inmates who are at the highest risk.

I think, additionally, we need to provide resources within our public schools for educational programming and counseling services so that kids are taught how not to become a victim. We also need to look at putting money into research to establish assessment and treatment of high-risk youths to slow or gradually slow down the rate of new offenders.

I know that all of these are monumental, and I was really very, very, very pleased at how well-informed the Commission actually was amidst what was going on this morning. At the risk probably of losing my job, very little of what you heard this morning was true, and the parts that were true were extremely distorted. That comes from right on the front line.

MR. MULLER: We had that impression.

MR. CONWAY: Extremely.

I have a caseload of 182 men. Like I said, this weekend I saw about 100 of them individually, and the vast majority of them are not receiving therapy as I think most of us

would think of therapy. They are receiving some classroom instruction, in some cases an hour and a half a week, and in a lot of cases, an hour and a half a month.

MR. MULLER: Question: What would you say is an appropriate caseload for you, given the nature of the offender?

MR. CONWAY: I think the Department's own standard is 50, okay, of a caseload for me. I would say a caseload of 100 in my position and my role. My role as a social worker, and currently I think we've all been kind of thrown into a role where we're all kind of considered equal treatment staff -- maybe not equal, but whether you're a psychologist or social worker, we're just kind of all thrown in. I had been running ten groups a week, and I had no problems doing that. I really like running groups. Currently I'm assigned two.

MR. MULLER: Do you chart daily?

MR. CONWAY: Chart daily, no.

MR. MULLER: Weekly?

MR. CONWAY: I keep case notes of my own, but as far as a chart, we don't have-- There is no chart existing that we can chart in.

MR. MULLER: Yes. I had brought that up early this morning, and my colleague, Assemblywoman Wright -- you have a nursing background, yes? And we had asked that the first session--

ASSEMBLYWOMAN WRIGHT: The second session, yes.

MR. MULLER: And they told us they did not keep progress notes and treatment plans and all that. And then today they told us that that wasn't true. That that was a misnomer that someone told us. That they in fact did keep those. So when I ask about charting--

ASSEMBLYWOMAN WRIGHT: We didn't ask-- It was a broad question, today, I believe.

MR. MULLER: No, but I asked specifically today, the gentleman that was on this end (indicating) and he said that he

didn't believe that that was an accurate assessment from the clinicians from the last time. I think he will bear me out on that.

ASSEMBLYWOMAN WRIGHT: Well, I think it's people use the word progress. I think this gentleman, the social worker himself, is talking about what we know as progress notes. I think they sensed today we were talking about a record of treatment.

MR. MULLER: Well, that's what I'm looking for, some kind of a record, that his notes and her notes and his notes, so that whoever picks up the chart can say, "Okay, this is what happened this time. This is what happened that time."

MR. CONWAY: Very seldom--

MR. MULLER: There should be.

MR. CONWAY: Very seldom do the departments even communicate -- or are the departments even able to communicate.

DR. JACKSON: I would agree with you. I must say, I would agree with you, that ideally we would chart our treatment. However, when I'm dealing with 82 offenders in group, it's simply not possible.

It is also the case that there has been a question for us recently as to whether our progress notes can be subpoenaed as evidence as a result of the fact that we work inside a State facility. That has made us even more reluctant to keep carefully documented notes because they can be subpoenaed.

MR. MULLER: But then how do you evaluate how the patient is progressing? I mean, perhaps we need to look at something in the regulations that allow-- You know, we were talking about confidentiality before, wouldn't you think that something like medical records or charts would be appropriately confidential so you can chart the progress of the patient?

MR. CONWAY: It would be wonderful for everybody who-- And especially now, the way that this modular program is going to be working, where every 14 weeks the guy is going to flip

over, who is doing his therapy, because there is not going to be any continuity. There is not going to be any way of knowing-- If Kay worked on something in the last 14 weeks with a guy, how am I going to know that. It would be impossible.

MR. MULLER: What if you picked up something, and you didn't get a chance for an interview with your colleague to say, "By the way, look out for the (indiscernible) or such and such, and such and such." you wouldn't know that, so you start all over again. Sometimes it might be missed.

DR. JACKSON: At the risk of sounding like an insurrectionist, that's exactly why we have substantial difficulty with this programmatic change--

MR. MULLER: All right. Thank you.

DR. JACKSON: --because a great deal of knowledge is lost. There is also, though Avenel is considered a passive institution in terms of actual, physical aggression inside the facility, it is a highly passive institution, and information regarding an individual's potential for acting out is also getting lost.

ASSEMBLYMAN MIKULAK: Gregg, others of us noticed that there have been disparities between administration's answers in the first meeting of November 1 and today. That's why we have transcripts, and this is all transcribed so we can compare them at our leisure.

MR. MULLER: It amazes me. It just absolutely amazes me. There is a basic loss of professionalism, clinical-- It just doesn't work.

ASSEMBLYMAN MIKULAK: And it's not too smart, either, because it's all on record. They're talking on microphone.

MR. CONWAY: I think it also needs to be pointed out that those of us who are before you today are doing so at the risk of losing our jobs. We have already been targeted. They tried to pressure us out of testifying before you today. We will definitely be the targets when we go back to-- You know,

when the layoffs come out, and they have the right to do the layoffs, we will be the targets for speaking out and speaking out for change.

ASSEMBLYMAN MIKULAK: Maybe we should meet with Commissioner Fauver before we wrap this up.

ADTC STAFF MEMBER: Excuse me a minute, but I really have to intervene at this point and disassociate myself from that last remark. I've been sitting on my tush and biting my tongue for the last few minutes here.

DR. BROOKS: Could you speak up, please.

ADTC STAFF MEMBER: Yes. I really want to disassociate myself from that last remark that my colleague made -- Mr. Conway. Different people may have different perceptions and may have had different experiences. I, for one, don't feel that my job is in jeopardy in any way for testifying in front of you. Mr. Conway may be in a different situation, I don't know. But I really do not have the same perception on that issue.

I also want to say to the Commission that some of what you've heard today is inaccurate. Both some of what you heard this morning and some of what you just heard is inaccurate, and I think you would be well advised, if you can, to meet again and clarify some of these issues because some of the facts -- some of the things I just heard stated as facts, aren't.

SENATOR BASSANO: One of the problems that this Commission has is that it has a chief responsibility to form a report, which will probably be looked at legislatively. It becomes impossible for us to legislatively run an institution. At some point in time you have to hire people that you hope have the qualifications and the knowledge to move forward in running that institution. The best that we can promise you is that there will be someone looking over their shoulder so that the legislative intent -- and I want to underline that word, intent -- is followed.

We will make some specific recommendations. I don't know if the people up here have the expertise -- I certainly don't -- in determining what program is best for the inmates at Avenel. I think we can make some general recommendations as to how we're going to safeguard the public and the amount of therapy that we would like to see administered. But I think to say to you that it should be a program from here or a program from there, I don't think we posses that type of expertise, even with regard to the change that is being made.

From what I'm hearing, there is a lot of dissatisfaction. I don't know that much about the program to be able to render an opinion as to whether this change is good or not. I have two people, two groups -- this group here and the people who were here before -- on different sides of this issue, one saying it's good and the other saying it's not good. I'm not qualified to sit in judgment.

So I hope that you understand that. I don't think anyone else up here is qualified to sit in judgment in that area. We want to hear what you have to say because it's important to us in helping to make some of those decisions that we can make, but recognize, there are some things that we just can't decide on.

DR. JACKSON: All I'm saying is, please be careful about your judgment about what you've heard.

ASSEMBLYMAN MIKULAK: But we've heard this before, so we have something to go by. That has nothing to do with what you people have testified to this afternoon. But what was said this morning and what was said in November, I feel, doesn't jibe, and when we get this thing transcribed, we're going to find that out and then we're going to have something to go on. I don't think it will end as soon as it should have.

SENATOR BASSANO: Assemblyman Zisa, then Senator Matheussen, and then Barbara.

ASSEMBLYMAN ZISA: First of all, I'd like to direct this to both of the witnesses, so that I'm clear in my mind on what we heard this morning versus what we're hearing now. I know there is a break in the treatment because of the implementation of the new treatment program, but are you saying that when it is fully implemented there will be fewer programs available to the inmates and there will be less treatment time that the inmates will actually have in terms of rehabilitation? Is that what you're saying, or is that happening because you're in a break right now?

MR. CONWAY: More programs, less treatment time. And the break was over effective Monday, okay. This past Monday, the program was implemented against a lot of our judgment. We did ask for a little bit longer break so that we could get this thing right, and we were mandated this Monday was it.

ASSEMBLYMAN ZISA: So there will be absolutely less treatment time available to the inmates?

MR. CONWAY: Right.

DR. JACKSON: I cannot speak for the entire program at large. I can only speak for my individual caseload, and I again will say that for 81 out of 82 men, this represents a reduction in the sheer number of hours of contact that they will have with either a therapist or a social worker. So I have difficulty imagining that if for 81 out of 82 it represents a reduction, if that would not be at least in some way representative of the rest of the inmate population. That is for one inmate, he got one more group than what he was going to.

ASSEMBLYMAN ZISA: Then let me ask you this. If in this new program somehow or other it is presented in a more comprehensive and thorough manner, would it be possible for it to actually be more effective even if the actual time was reduced, or would that be an impossibility?

MR. CONWAY: No, I think that it could be more effective if we looked at accountability, if we looked at

maintaining what was good about our old program and adding what needed to be added, okay, not just scrapping the whole program when there were significant pieces that worked.

Specifically what I would call -- I would call it more therapy. The program we have now is psychoeducational in nature, which is much like a classroom. There is very little actual what I would call therapy going on. There are therapeutic programs, very much needed programs, but I don't feel that you're going to do a whole lot by asking a guy to spit back out what I just told him. Whereas, if Dr. Jackson had the opportunity to build that into his person as a construct, we might be able to expect him to be able to utilize it in his life.

DR. JACKSON: Assemblyman, I also would like to say that part of the source of my concern about this is that I reached out prior to the implementation of this new program last week to the head of the SCRB -- that's Dr. Nathan Pallone (phonetic spelling) -- and he has expressed to me great concerns about how this is being implemented, as well. He has been an expert in the treatment of sex offenders for the last 25 years, and he suggested that this makes absolutely no sense and was willing to be quoted.

Contrary to the administration's presentation that there is enthusiasm about this, there are some people who are interested in seeing it happen, but there are a lot of people who are deeply concerned about it.

Again, we have a wide range of offenders here. We have offenders who will be with us for what we consider to be an unusually short period of time, and we're very concerned about those people. They have, through plea bargaining, through a variety of means to circumventing jail time. We have an offender who came in who has been arrested 22 times, and he has a four-year sentence. That means that he will be with us, after county jail time, for 18 months.

After this new program, this offender who was in four groups is now in one. He is leaving in 10 months. We have a four-month cycle. That means that he has one more chance to get five groups that I've recommended for him. It's not going to happen.

MR. CONWAY: That's a very important point. The length of time-- We're constantly hearing, when we bring up feedback about program implementation, "Oh, well, the next cycle will be different. The next cycle will be different." But as you've heard somebody state, that we released -- or they did exit evaluations on 50 inmates. In that time period, are you willing to put 50 of these guys on the street, while we're trying to work out the bugs in the program. I don't think so. I'm not willing to have them move into my backyard.

SENATOR BASSANO: I think that when we issue a final report that some of the recommendations that we make will not result in people being in Avenel for 18 months. It will be a different type of system.

DR. JACKSON: Good. Because I'm good, but I'm not--

SENATOR BASSANO: That doesn't solve my problem if we do what I think we're going to do for those people who have been sentenced under the Penal Code that's in existence now. You're still going to have to deal with those folks, because there are people now that are in Avenel that were sentenced under the old Penal Code, which is what we're talking about going back to.

Before we go any further, I know there is one other person back there who is involved in Avenel. I'd like to bring her up so--

MR. CONWAY: I also have to leave.

SENATOR BASSANO: Yes. --I can hear what she has to say.

ASSEMBLYMAN ZISA: Senator, before they leave, I just wanted to finish up.

SENATOR BASSANO: Go ahead, Assemblyman.

ASSEMBLYMAN ZISA: My greatest concern out of everything that has come out today, I want to be very clear on.

Ms. Jackson, if you could just finish up.

DR. JACKSON: I'll scoot over here so she can--

ASSEMBLYMAN ZISA: Did I understand you correctly when I thought I heard you say before that you feel the administration today purposely misrepresented the facts, and that they were untruthful to the Committee?

MR. CONWAY: Absolutely so.

ASSEMBLYMAN ZISA: Do you feel the same way, Ms. Jackson?

DR. JACKSON: Yes, I'm afraid I do. And I say that with all willingness to seek new employment tomorrow for having been prepared to say that.

ASSEMBLYMAN ZISA: The reason I ask that, and the reason I want to be very clear on that, and this is what I now will offer to the Chairman, and I feel very strongly about it.

This really goes beyond our original mission. I understand that we are here to make recommendations as to the future of the institution, and I understand that that is what ultimately will come out of it. But I want to suggest at this point that we go beyond that. I want to suggest that we initiate an investigation through either the Attorney General's office or whatever the Chairman feels is appropriate.

We have two completely conflicting accounts that are being given to us by the people that we employ in a very important part of State government.

SENATOR BASSANO: I don't know if we have to go as far as an investigation. I know we're getting two different scenarios. Maybe what we ought to do is, through correspondence with Commissioner Fauver himself, have him clarify for us this matter, and if necessary, have him appear before this group to clarify this matter.

Of all the people in the Cabinet, he has to be one of the least political, having served in both Democratic and Republican administrations and just carried forward from one administration to the other. So I don't think we are going to see a political individual before us, but I think if we want to bring him before us, it certainly is something that we may want to consider.

ASSEMBLYMAN ZISA: Whatever vehicle you feel is appropriate. My point, in closing, though--

SENATOR BASSANO: I don't have a problem doing it. I know that Assemblyman Mikulak talked about the idea of maybe bringing him forward, and maybe we can clarify this once and for all.

I don't know if we have the capability of sitting in judgment on the issue that is being brought before us. I see where they're coming from. I hear from the administration. That's beyond what we were charged to do.

ASSEMBLYMAN ZISA: But my point is this. We formed a joint legislative task force as a function of State government. There is an obligation on the part of the witnesses to appear here and to be truthful with us. If they have come here and given false testimony knowingly and purposely, all I'm saying is that whatever vehicle we choose to use, I believe certainly that the right exists on the part of the State to discipline appropriately those who come before this type of committee and give false testimony.

I just wanted to put that out on the table, because I feel very strongly about it. We cannot perform our function, and they cannot perform their function if people will come here and purposely give us information that they know to be untrue. And I think if we let it go by and don't do anything about it, we undermine any future actions on the part of the Legislature that we ever undertake in regard to forming committees, because it's pointless if people think they can come here and give us

whatever information they want and nothing will ever happen as a result of it.

SENATOR BASSANO: I'm willing to entertain a motion, if you want to make that motion, to request that the Commissioner make himself available the next time we meet.

ASSEMBLYMAN ZISA: If you want it in the form of a motion, Mr. Chairman, I have no problem at all--

SENATOR BASSANO: If you want to make that in the form of a motion, I'm willing to entertain it.

ASSEMBLYMAN ZISA: I move that we have the Commissioner come before our Committee.

SENATOR BASSANO: Is there a second to that motion?

MR. THOMAS: I second it

SENATOR BASSANO: Can we take a vote of the people who are here?

MS. STEFANE: On the motion: Senator Bassano?

SENATOR BASSANO: Yes.

MS. STEFANE: Assemblywoman Crecco?

ASSEMBLYWOMAN CRECCO: Yes.

MS. STEFANE: Assemblywoman Wright?

ASSEMBLYWOMAN WRIGHT: Yes.

MS. STEFANE: Assemblyman Zisa?

ASSEMBLYMAN ZISA: Yes.

MS. STEFANE: Professor Brook?

DR. BROOK: Yes.

MS. STEFANE: Mr. Muller?

MR. MULLER: Yes.

MS. STEFANE: Mr. Thomas?

MR. THOMAS: Yes.

SENATOR BASSANO: I would ask that Anne contact the Commissioner and that she alert the Commissioner to make himself available for the next time that we meet, and also to make the Commissioner aware of what we're going to be asking him regarding what transpired today.

ASSEMBLYMAN ZISA: I would also like to just add, ask that we have the transcripts be made available as quickly as possible, because I'm sure there will be some very pertinent information in those transcripts which will be helpful to the Commissioner.

SENATOR BASSANO: We think that in that short period of time, it shouldn't be that difficult to try and make it available to all the members.

ASSEMBLYMAN ZISA: Assemblyman Mikulak pointed out before that every statement is recorded, so I think that--

SENATOR BASSANO: Well, I'm going to look for one more meeting, if we can. I'd like to see us bring in a couple of experts from around the country to see if we can maybe get an idea from them what they would suggest as to a pyramid effect when it comes to providing therapy. Perhaps at that meeting, the Commissioner can start the meeting off.

Let's get back to what's happening here. The young lady who just--

ASSEMBLYWOMAN WRIGHT: We wanted to make a few comments before you proceeded.

SENATOR BASSANO: Did you want--

ASSEMBLYWOMAN WRIGHT: One is--

SENATOR BASSANO: Excuse me, Barbara. Please feel free to do so.

ASSEMBLYWOMAN WRIGHT: I thought somebody else was ahead of me, but-- One of the things that is clear to me is that we don't have Dr. Nancy Steele's report, and we need to request that.

And I think the second thing is that perhaps if we are going to deal with experts, one of them should be Dr. Nancy Steele because she is the only expert in the country who has had any hands-on experience with our program. If it sounds like the one thing that we have had that has been consistent has been a

respect for Dr. Nancy Steele from the administration as well as from the professionals.

Right? Am I correct in--

DR. JACKSON: Yes, I have a lot of respect for Nancy Steele from what I know of her. I would also like to suggest that you ask Dr. Pallone to address you. He is the person who is the head of the Special Classification Review Board, and he has been for many, many years. He is quite familiar with Avenel, and he is Professor Emeritus at Rutgers University.

SENATOR BASSANO: Anyone else? (no response)

Without mentioning your name, please feel free to address the group.

S U Z A N N E C. B E S H A K: By the way, I don't mind if my name is used. I clarified that in the beginning.

Before I begin, if someone would be -- hand these out for me. These are copies of my remarks. Also I have a copy here of a proposal that I submitted to our administration three times. This is one of my key areas of interest today that I'm going to talk about. So, if you would all like to look at that.

And also before I begin, I promised my colleague, Becky Ossont that I would apologize for her. She had to leave due to a day-care issue. She said that she hoped that she could be rescheduled at another time to be heard.

My name is Suzanne Beshak, and I have held the position of Substance Abuse Counselor with the ADTC since December of 1986. I have bachelors degrees in psychology and criminology from Rutgers University and have fulfilled the necessary education and work requirements for my certification in alcohol and drug counseling, which I should receive this spring. With my education and experience, and with the help of my co-counselor, for the past four years, I have developed and implemented the Substance Abuse Program at Avenel. In my remarks it says "it is." It should say "it was" the most

comprehensive program in terms of amount and variety of groups being offered at any correctional facility in New Jersey.

During the past several months, I have served on our Treatment Program Revision Committee and worked to modify the Substance Abuse Program to conform to the new 16-week module system. Rather than cover ground already covered by my colleagues, I will simply support them in that, first, I agree that the new program with its time constraints hinders both the therapeutic process and the elements of trust and rapport that must evolve in any therapeutic relationship between clinician and client.

That's a real important point. Kay raised it, and Craig did also. I believe a previous witness did also, that it's really important that you maintain contact with these people and not just jump around every 14 weeks to someone different. One of you posed the question before, "What is a case manager?" In my view a case manager is nothing more than somebody who is coordinating a man's schedule and receiving reports from a variety of other sources and may not actually have anything therapeutically to do with that man, okay. And yet he is referred to as the case manager/primary therapist. So I do see that as real important.

I feel that inmates have been haphazardly placed in groups with little attention paid to therapeutic need, progress, or outcome. Frankly, the new module system reminds me of a college admissions board wherein advisers are scrambling to make sure everyone has some class or other to attend merely to round out a schedule and fulfill credit requirements. I see little care given to course content, staff training, and overall impact and effectiveness.

I would emphasize those points also. They talk-- In fact, there have been articles in the media of the training that we are receiving, and I can tell you personally, I haven't received a real lot of training. And as far as course content,

I know that we're scrambling to put together curriculums, you know, subjects and outlines, but as far as what is actually going to be done within each session, I'm not real clear on any of it.

In terms of substance abuse, we are severely lacking in adequate funds for professional materials, training, and time to focus specifically on substance abuse treatment. We currently have just two counselors on staff to serve a population of 740 men. Other institutions have, and rightly so, funded, focused, segregated programs with larger staffs dedicated only to an identified substance abuse population. At Avenel, our efforts are diffused due to disorganization and addicted inmates being scattered throughout the facility.

Furthermore, statistics provided by the Bureau of Community and Professional Services in Trenton show that in excess of 70 percent of our inmates struggle with chemical addictions while only 2 percent are presently enrolled in a counseling group. We have 15 men in a counseling group of 740, right now. Another 5 percent are involved in substance abuse education classes. I would estimate then that an approximate 7 percent, or 50 out of a possible 520 who need substance abuse education and counseling are receiving it this semester.

At this juncture, I would like to turn my focus to issues of even deeper concern to me. I'm speaking of the prerelease and postrelease process of sex offenders. First, allow me to address the two points I believe we can all agree on:

One, all of us here today are deeply disturbed by the cruel, despicable victimizations of Megan Kanka, Amanda Wengert, and countless other victims.

Second, we would all like to prevent such victimizations from ever recurring and do so as quickly, efficiently, and cost-effectively as possible.

at proposing an aftercare program for substance abuse issues, my requests were repeatedly denied by our administration. Even though I committed myself to taking full responsibility for the program and adjusting my schedule accordingly, my recommendation was met with disinterest. I argued the necessity of this program, pointing out parole violations due to drug use, reports of other ex-inmates using drugs, and inmates not yet released expressing fears of relapse if the pressures on the outside were too great. It stands to reason that if an ex-offender begins to drink or use drugs again, the chances of his recommitting a sex crime are great.

I really want you to understand this. At times I feel like presenting to the administration at Avenel and the treatment staff-- I say to them, you know, all these groups that we're running and all the therapy that we're doing, if the men go out and drink and use again, it's all down the drain, it's all forgotten, it's over. Because once they pick up those substances -- and we're talking about better than 70 percent of the population -- once they do that, all our efforts are wasted. That's how important aftercare treatment, I believe, is.

Then I was reminded that we do provide referrals to treatment centers and 12-step programs on the outside. But I further argued that an ex-offender needs the freedom to discuss his alcohol or drug problem in tandem with the pressures and fears of also being a recently released sex offender. I can tell you honestly that such discourse would not be well received in any AA meeting I've ever attended. So I appeal to your common sense. If we are spending thousands of dollars annually per inmate for in-house treatment, why not take a nominal percentage of those funds and apply them to necessary aftercare treatment?

Again, you know, the party line seems to be, "Well, there are plenty of community-based programs." But there are not plenty of community-based programs or even 12-step support

The questions we need to be asking ourselves are, first, what are the best methods of achieving those goals and what can we do as treatment professionals, legislators, concerned citizens, and taxpayers to ensure the unlikelihood of any more victims?

The facts are that offenders preparing for release -- and I work specifically with men who are going out. That's of a big interest to me. These men need housing, employment, emotional support from family and friends, financial assistance in some cases, fairness within the justice system, and aftercare treatment in order to become responsible, productive members of society. Some offenders have all of these basics in place; some have a few; some don't have any. I want to challenge you at this point and ask, if you were a released sex offender venturing out into the climate that exists today and had no housing, no promise of employment, little emotional support, a vacillating justice system, and no aftercare treatment made available to you, where would you go, and what would you do?

Please understand, I'm not looking for sympathy for these men. I am, however, identifying real concerns that affect all of us, potential victims and sex offenders as well. I believe that Megan's Law is an attempt to take control and secure the safety of women and children in our State. But I submit to you that with all its good intentions, it falls very short of the mark. My aim is not to debate Megan's Law, but rather, to discuss what other steps need to be taken to prevent any more victims. Let's begin with aftercare treatment. That's already been a big issue and I'm thrilled to hear that.

Aftercare or outpatient treatment is a common practice among most therapeutically based treatment centers. It's a critical component in helping a patient make the transition from a structured environment back into family life and society. Avenel does offer a limited amount of aftercare to address the problem of sexual compulsivity. However, after three attempts

groups where an inmate can go in and say, "Well, I just got out of Avenel, and I'm having these deviant fantasies, and I want to drink because I'm feeling bad about myself." They can't hear that, not even in an AA meeting. That's probably one of the most liberal places that you could go, and they can't hear that.

I'm also concerned about immediate housing for former offenders. With the new registration laws requiring an inmate to provide an address 90 days prior to release, many are unsure of where they are headed. Just last week, four men came into my office who had addresses but lost those privileges due to their families' perceived risks associated with notification. For all intents and purposes these men will be homeless until alternative housing can be found. For this reason, I am strongly advocating halfway housing for sex offenders; a place where they can live temporarily and be monitored as they adjust to living in society.

SENATOR BASSANO: How many people do you believe that are released from Avenel would actually utilize halfway housing, or would have a need for it?

MS. BESHAK: Percentagewise?

SENATOR BASSANO: Percentagewise, yes.

MS. BESHAK: I don't want to just throw out a figure, but I'd say-- And what is happening is that number is increasing because people's families or other places that they were going to go are now real leery about taking them in because of exposure for themselves and their families, so I would say maybe that number used to be between 10 percent and 20 percent, and is now rising. It's hard to say, but I'd say 20 percent, 40 percent; between 30 percent and 40 percent.

Do you have any--

DR. JACKSON: I couldn't--

MS. BESHAK: It's really hard to gage that. I can tell you that the number is rising. I'm working specifically now in a group with men who are due to be released between now

and June 30, and I'd say half of them know exactly where they are going and are able to register. The other half do not.

SENATOR BASSANO: Continue. I'm sorry.

MS. BESHAK: Released offenders also need security and acceptance in public housing domains and the job world. In order to achieve these goals, fairness in the justice system must be clearly defined and maintained. The three-tier classification system to assess the risk of a released offender is a functional and applicable idea. Unfortunately, this process has been removed from the hands of competent treatment professionals who have expertise in these matters and left to the discretion of county prosecutors. I can appreciate and respect the level of fear, anger, and even an inclination for revenge against these perpetrators. Yet, in our haste, are we not adding fuel to a fire already raging out of control? Logically, if we create an environment where it is virtually impossible for the offender to reacclimate, know that his chances of recommitting a sex crime are even greater.

I want to emphasize that again. You know, we talk about treatment and we talk about support, but all of this goes out the window if you put somebody in a place where he can't possibly function and can't possibly survive, and his fears of vigilantism or whatever else may happen to him are so great that he just can't hold it together.

SENATOR BASSANO: I think we understand what you are trying to say. As we stated earlier, when we talk about extremely long-term paroles with certain specific recommendations to meet that parole, the public will have some type of registration, will keep track of people coming out of Avenel. I think that should satisfy a lot of the concerns.

MS. BESHAK: I'm not even speaking so much about parole; although I think parole is an excellent idea, and to my knowledge there is only about 2 percent presently who are being paroled.

SENATOR BASSANO: Right now, yes.

MS. BESHAK: But I'm talking about men who are maxing out, which is the vast majority. I'm more-- Personally and professionally, I'm working with men who are afraid to go outside, who don't know what they are going to do. Some of them would rather stay inside, okay. We used to be able to tell them, "You know, if you go out there and you go to your support groups and you do everything right, you're going to be all right." It's very difficult to say-- Most of them are telling me, "I'll never be free. I'm going out to another jail." That's their view of it.

So what I'm really talking about is just calming down the hysteria that is going on outside.

Specialized parole officers for sex offenders and indeterminate sentencing are also constructive ideas. Again, you are placing the burden of responsibility with the people who are trained, who know what they are doing. Also, considering the mismanagement of the system as it exists today, be aware that many offenders are seeking refuge in other states where notification laws are less strict or don't exist at all. This is not Avenel's policy to advise them to do that, but I'll admit to you that in some cases, when a man absolutely has nothing else to do, I'm encouraging him, maybe that's the best thing for you. Then I wonder, how fair is that suggestion to our neighboring states.

In conclusion, I implore you to take the time and consider the realities of the situations we are facing. With Megan's Law in place, please recognize the additional steps, and yes, tax dollars that may need to be spent in order to truly provide safer communities for our vulnerable citizens. Realize the inherent dangers of applying too much pressure and extending no support to sex offenders whose futures are uncertain and unstable. Let's not kid ourselves and believe that by knowing where a sex offender lives or works that we can control his

behavior. Instead, let's generate treatment and support that will help him to remain healthy and on the path of recovery. Let's put our emotions aside for now and think clearly and objectively about the tactics and strategies that will really work. Let's truly put a potential victim's interests first and boldly bring this chaotic situation under control.

ASSEMBLYMAN MIKULAK: Thank you.

Who is next on the list? Do we have any questions.

MR. MULLER: I think our Senator went to get one of our people who may have to leave.

ASSEMBLYWOMAN WRIGHT: I just have one question, Assemblyman Mikulak.

As an expert in the field of substance abuse, why do you think there has been so little attention to treating that portion of the disease that we experience here in the inmates?

MS. BESHAK: The emphasis at Avenel is always sex crime, and I feel the people are just very ill-informed, if you will, about the correlation between substance abuse and sex abuse. Frankly, even many of the treatment professionals are unaware or just don't know that much about addictions, and as was pointed out before, we don't communicate a lot. In the past they haven't required reports from me; although I do submit reports. But we don't often confer on them.

People need to understand that there is a very strong link and direct correlation between substance abuse and sex abuse.

MR. MULLER: What is your caseload? Could you say?

MS. BESHAK: Honestly, it shifted so dramatically Monday, it's hard for me to give you an accurate number.

MR. MULLER: It was like 200. Wasn't it something like that?

MS. BESHAK: The men that I was actually treating monthly, and we were providing quarterly statistics, was between 50 and 70. The reason for the low number is that the only way

I got referrals was from other treatment professionals who thought that their men needed substance abuse treatment. So there are actually many men in the system who are not being treated because their primary therapist didn't deem it that important.

MR. MULLER: Would it be helpful if you had more resource tools such as RATE, or ASAM biopsychosocial model assessment tools and things of that sort?

MS. BESHAK: We have just received, or we're about to receive the ASI -- the Alcohol Severity Index -- as an assessment tool.

MR. MULLER: But you need to throw in RATE and maybe the biopsychosocial with it, because the ASI by itself--

MS. BESHAK: Yes, that would help. We need a lot of things. We need books; we need literature; we need videos. We don't have any money.

MR. MULLER: I saw your AA ones, when we did the tour of the facility, a couple of posters on the wall.

MS. BESHAK: Yes, that's it. And the things you did see were donated by outside sources. We don't get anything.

MR. MULLER: Well, I, for one, want to congratulate you, because I work in a hospital facility that does addictions, and I asked them if the 70 percent number that runs correspondingly to regular criminals runs here, and I was told absolutely not. It was like 20 percent. Then I saw you and I saw your room and I thought, well, maybe I'm wrong. And then I get this letter from you, and it says, "More than 70 percent of these inmates abuse substances." The minute they take a substance again, there goes all the treatment.

MS. BESHAK: Right.

MR. MULLER: They relapse. The whole thing falls into play.

MS. BESHAK: So, if you haven't heard anything else I said today, I'm really pushing for the aftercare. Our

administration really could not hear what I had to say. Three times I brought it before a committee -- that proposal that I handed out.

MR. MULLER: Senator, I would very much appreciate it, from those of us who are in this field, that you would include some appropriate nomenclature, comment, or something to look at that issue, if not through us but through their clinical specialists at the facility.

SENATOR BASSANO: Gregg, I feel strongly that we're going to have to establish some type of aftercare. I think if you do that in conjunction with the parole system that you get a much more effective system itself. I think that the Committee or Commission will basically agree with that. We'll talk about that.

MR. MULLER: Right. There are cost-effective facilities all over the State that will take the people through (indiscernible) and other programs.

SENATOR BASSANO: We may want to privatize that. We may want to have the State do it. We may want to have both, depending on the area of the State. But I think you're going to have to look at the State as a whole and have something of that type, at least in different portions of the State, where people can go once or twice a week if their parole mandates that.

MR. MULLER: Because that's an addiction, and the addiction that they have, this obsessive-compulsive behavior is also an addiction.

SENATOR BASSANO: That's what I've been saying right along.

MS. BESHAK: As it--

DR. JACKSON: It also is true--

I'm sorry, Sue.

It is also true that we are supposedly using an addictive model.

MR. MULLER: Yes, yes. But it doesn't make sense to me.

ASSEMBLYWOMAN WRIGHT: Senator Bassano?

SENATOR BASSANO: Yes.

ASSEMBLYWOMAN WRIGHT: I think that-- If I'm hearing the point that Gregg is making is that we can't parcel out these behaviors, and that-- Seventy sounds high, even though I wouldn't want to debate it. I just think that everybody who is being diagnosed here should be screened with some of those tools. I think that's--

MR. MULLER: Yes, you need to make some form of the treatment modality include those other screenings.

ASSEMBLYWOMAN WRIGHT: --in a sense-- I want them in diagnosis to rule out this piece--

MR. MULLER: Absolutely.

ASSEMBLYWOMAN WRIGHT: --because they're not getting addicted to alcohol and drugs, I don't think, when they get here.

MS. BESHAK: No, it's prior to.

MR. MULLER: No, it's before, and if it remains untreated, Assemblywoman, if I may -- if it remains untreated, the day they go out the door they go back to it.

MS. BESHAK: He's correct.

ASSEMBLYWOMAN WRIGHT: But the vital part of it is is that they're getting exposed to a lot of treatment here, and even when they're being treated for their sex offenses, as I think Kay just said, is that some of the-- The modalities don't change. If you're in an addiction model, and you're looking at self-responsibility, and you're looking at changing your behavior from inside out, you're doing the same things. But I think what is key is that perhaps these people be screened on admission and diagnosis and that it be a part of their-- Even if they don't all get to see Suzanne, their own counselors could benefit from this information, I would think.

MR. MULLER: And could deal with the therapies necessary.

MS. BESHAK: We do have a method of screening that we've used for years. In fact, all the screening tools and intake tools that we use are something that I developed, okay.

ASSEMBLYWOMAN WRIGHT: But is everyone being screened?

MS. BESHAK: Yes, everyone is screened. For the past two years, yes they are. That is happening for about the past two years. That's where I come up-- That's also where I come up with that figure of 70 percent.

ASSEMBLYWOMAN WRIGHT: But that doesn't mean the other 600 who came before the past two years were screened. We still have--

MS. BESHAK: No, they weren't screened accurately. I mean, there was always some method of pulling somebody into your office that you thought or whatever, but in the past two years they have been screened.

ASSEMBLYWOMAN WRIGHT: And that will continue?

MS. BESHAK: Yes.

ASSEMBLYWOMAN WRIGHT: Thank you.

SENATOR BASSANO: If there aren't any other questions? (no response)

Bill, I know you had a statement that you wanted to read.

MR. THOMAS: Yes, I would like to make a statement.

My daughter, Karen Wengert, was here today, and she had wanted to make a statement but she was unable to because the meeting ran so late. She had to go home and take care of her two daughters. Paul Shaffler (phonetic spelling) was also with her, and he has been very active since the tragedy that took my granddaughter on March 6 last year. We didn't know Paul, and he stepped forward at that time when he found out what had happened and got together a lot of people that he thought would want to help and change some of our laws.

On his own, with the help of some others, he put together 16,000 signatures that we delivered to Trenton in May -- I guess it was May, I went with him -- bringing about the feeling of the general public as to what we should do or try to do to help prevent other such tragedies. That was in May.

After that, in July -- unfortunately I was in Saratoga that night -- and I read about Megan Kanka. It was unbelievable that it could happen within a short distance and in such a short time. Two girls, similar circumstances, both offenders from the neighborhood. The offender who was involved with my granddaughter, he had a problem when he was a juvenile, and that was sealed away with the juvenile records. Since then they've been released, and we've successfully gotten some legislation that will make those records available from now on.

So they had statements they wanted to read, but I think it would be better-- They said that I should read them, but I don't think I'm capable of reading them. I would like to-- I'd like to have them-- Maybe if we have another meeting we can let them say their piece first or early in the day.

But now-- I've said enough, but I've got another statement that I'd like to make. I am strictly an amateur on anything to do with sexual behavior or anything of that nature. I've never been interested in it; I've never-- Like so many other people, it's something you try to brush under the rug. Who wants to talk about that?

So I volunteered when I was asked to be a part of this Committee, and I really appreciate the opportunity to be a part of this. But because I didn't have any background in it, I have taken it upon myself to go out and do some research, and I'd like to read a statement.

At the conclusion of our last meeting, which was our second meeting, I expressed my feelings brought about by the tour of the Avenel facility and also my interviews with outside professionals regarding the confinement and treatment of sex

offenders. At that time I had met with and interviewed: a doctor of psychology, a clinical psychologist, a doctor of divinity, a county prosecutor, an assistant prosecutor specializing in sex crimes, and various other law enforcement officials.

My conclusion after my research was that Avenel did not appear -- this is only my conclusion, I'm not speaking for anyone -- did not appear to provide an effective solution in treatment or release of sex offenders.

Since our last meeting -- I've been away, but I started and continued more research. Somebody said to me, "You ought to talk to some other people, other than psychologists and prosecutors. Why not talk to the defense attorneys. See what they have to say." Well, I saw them and they said, "You know, Bill, we can't talk to you because we're defending the defendant that was involved with your granddaughter." Fine. So they referred me to the President of the New Jersey Defense Attorneys. And between those two organizations, they thanked me, but they had very little to offer. They were helpful, and they furnished me with some clippings that they had made and some research that they have done on the different meetings that we've had at Avenel.

But after that, I've been in contact with the director of corrections, with the director of special treatment for sex offenders in the following states: South Carolina, Georgia, Virginia, and California.

To summarize the findings:

The states that I interviewed do not use special segregated facilities for sex offenders. In the State of South Carolina, prisoners are subject to discipline, including restricted dress. They are required to take part in a work program, five hours a day, five days per week and use only common TV areas with selected programming. Group therapy is provided for those that request it and those who are found

suitable for it. No privileges, no carrots are given for the taking of treatment. Treatment is given within the regular prison, and it consists of group therapy, approximately four hours a week. One hour per day is required for study time if they are taking therapy. And close follow-up is required after release.

The State of Virginia: The governor's criminal justice reform, as of June of this year, includes the elimination of their treatment for sex offenders. After they had a study, it did not show the program was effective. There treatment will be discontinued in June of '95.

In California, after a five-year sex offender treatment and evaluation study, the state will terminate their sex offender program as of June '95. The study, again, did not show treatment to be effective. They are now imposing longer prison sentences in hopes that that will help.

In addition, I've yet to find a doctor of psychology, and I've talked to a number across the country, that will say that there is a cure for any adult pedophile, and there is only help for a small percentage of the offenders. For a released offender, monitoring is a must with the use of a polygraph -- this word I have trouble saying; I know what it means -- plethysenagraph, and possibly electronic monitoring. Therapy will only reduce the risk and never eliminate it.

In conclusion, it's my thought that we sentence our sex offenders in the State of New Jersey to serve their sentence at a regular State prison, to treat therapy as a privilege that must be requested and warranted, and furnish the treatment in that prison facility.

We should again ask the question of our administrators at Avenel, which I did earlier today, "Would they feel comfortable with the treated prisoners released in their neighborhood with their young children?"

It is time, I believe, that we turn our tax dollars to programs with better potential results. We can no longer be protectors of the status quo.

Thank you.

SENATOR BASSANO: Before we conclude, are there any other comments or questions. I think the hour is getting a little bit late. (no response)

If that's the case, then we're going to conclude today's hearing. We will try to get the Commissioner at our next meeting and try to do that as soon as possible, of which you will be notified. We'll also try to bring in some other so-called experts to address us to gain a little bit more knowledge before we have a meeting of the Commission itself to come up with some recommendations.

Thank you.

(MEETING CONCLUDED)

APPENDIX

Recommendations to the Commission Regarding the Adult Diognostic Center

Louise Riscalla, Ph.D.

Administration:

Under the current system there are many disciplines doing therapy such as Social Work, Psychology, Psychiatry, education, corrections, etc. with the consequence of a risk of inconsistency in the type of treatment given. There is no way of controlling the quality and type of therapy given by the various disciplines. For the purposes of consistency, it is suggested that an individual with a medical background and training in psychotherapy have complete control and supervision over all staff doing treatment. In addition, the amount of staff alone does not insure effective treatment. The quality of treatment must be maintained through in-service training in order to enhance needed knowledge and skills for the staff. There should also be consideration given to the use of professionals in the community, on a pro bono basis, to help deal with treatment problems and issues. An advisory panel of professionals could also be appointed to oversee treatment on an on-going basis.

Since the Diagnostic Center started, the prisons have increased staff who can provide treatment for sex offenders. Therefore, it is suggested that the Adult Diagnostic Center be closed and all sex offenders be placed in a prison with sections for diagnosis, treatment, and incarceration. In addition, there are always those individuals who could not benefit from treatment or may require incarceration on a permanent basis. For example, the geriatric offender could be placed

in a secured unit of a geriatric facility such as Hagerdorn or the Geriatric Psych. Unit at Greystone Park Psychiatric Hospital. Those requiring incarceration on a more permanent basis could be placed in the Forensic Unit of Trenton Psychiatric Hospital or the Krol Unit of Greystone Park Psychiatric Hospital. Another possibility would be to have a long term unit for sex offenders within a prison. All sex offenders could then have the opportunity for treatment. If prisons are too overcrowded to accomodate a sex offender treatment section, then use of existing facilities, such as vacated secured buildings at a state psychiatric facility might be considered, especially in view of the deinstitutionalization of psychiatric patients.

Legal:

The sex offender law should be revised so that the determination of treatment would be made by mental health professionals rather than the legal profession. An indeterminate sentence could provide the needed time for treatment, help discourage inmates from cooperating with treatment in order to be released at a particular time, and would take into consideration the unique make-up of each individual.

Members of the legal profession should not interfere with or dictate the type of diagnostic instruments used, medication prescribed, and or treatment given which could be construed as practising medicine without a license.

Diagnosis:

It is impossible to do effective treatment without knowing what is going on within the individual. Diagnostic accuracy is essential. Each sex offender should first be evaluated in a diagnostic unit. This evaluation should include, but not limited to a complete psychological assessment that includes individual intelligence testing, neuropsychological evaluation in order to rule out neurological factors, personality testing, and vocational testing. A psychiatric

2X

examination should include a Sodium Amytal interview as originally permitted at the New Jersey State Diagnostic Center, neurological examination, Electroencephalogram (EEG) which include nasal pharangeal electrodes or other means of reaching the limbic areas of the brain, and relevant blood work. The medical examination should also rule out any possible contributing medical conditions. A psychosocial assessment would include family background, detailed medical history, previous hospitalizations, community and private resources used for treatment, present legal problems, history of acting out behavior, and educational history.

Treatment:

Treatment is determined by diagnosis and motivation of the individual. A variety of treatment modalities should be available because each person is unique, including life circumstances and offense. Some individuals may require psychotrophic drugs or other medications and require the care of a psychiatrist, neurologist, or medical doctor depending upon the nature of the illness requiring medication. Some inmates may consent to treatment in order to gain release and not to change behavior. There are others who will refuse treatment as is their right under the law. Motivation to seek help can not be mandated. If the inmate refuses treatment, then since a crime was committed, correctional treatment should be mandated. In any case, screening inmates for treatment, including an assessment of motivation for treatment is essential prior to starting any treatment program.

Group therapy should be limited to 10 inmates per group, be of 90 minutes duration, and supplemented by individual therapy if necessary. There are some people who do not wish to discuss personal matters in a group. In such a case, individual therapy would provide the opportunity for privacy and a more specific focus on personal problems.

3X

A strict behavior modification therapy is not advised because any change is limited to the conditions under which learning takes place. This learning cannot usually be transferred to another place such as the community

Classroom methods of teaching behavioral change using books and other materials do not appear to be effective because it is an intellectual approach which may not help the individual discover inner personality dynamics which are necessary for any permanent change of behavior.

A modified twelve step program similar to the one used by Alcoholics Anonymous (A.A.) appears to be most effective because it is based on self-examination, inner realizations, a real desire to change, and, in short, a transformation of character rather than surface modifications. Since the Sex Offender Act indicates that the behavior must be repetitive and compulsive, which is actually addictive sexual behavior, a twelve step treatment program seems consistent with the needs of the Sex Offender Act.

Research:

Research is costly, and it is impossible to accurately assess the effectiveness of treatment due to the uniqueness of the inmate, the many people encountered in the course of treatment who have an impact on the inmate, salient variables (those which can't be quantified yet impact on results), and the personal attributes of the researcher. Often, when evaluation or planning type research is done, by the time the recommendations are implemented, the program being evaluated could be obsolete because of changes taking place in the system or budgetary constraints.

RECIDIVISM STUDY VARIABLES

fender Demographics

. Name:_____

. Birth: Month:_____Day:_____Year_____

. Social Security Number:_____-___-_____4. ADTC Number: DN_____

. FBI Number: _____ 6. SBI Number: _____

. Received: Mon:____Day:___Yr:____ 8. Released: Mon:____Day:___Yr:_____

. Type of Discharge: (Circle one)

Maximum Parole Transferred to another Institution Deceased

. Race: (Circle one)

Black Non-Hispanic (Caucasian) Hispanic Asian American Indian

Other (Specify):_____

. Gender: (Circle one) Male Female

. Marital Status: (Circle one)

Married Steady Relationship Sporadic Relationships

No Relationships Divorced

. Employment History: (Circle one)

Steadily Employed Sporadic Employment/Employed at time

Sporadic Employment/Unemployed at time Unemployed Retired

. Religion: (Circle one)

Catholic Protestant Jewish Muslim Hindu Buddhist None

Other (Specify) _____

. Education: (Circle Highest Level Completed)

Elementary:	1	2	3	4	5	6	7	8
High School:	9		10		11		12	
College:	13		14		15		16	
Graduate School:	17		18		19		20	

Specialized training:_____

xual Abuse History of Offender (Circle ALL that apply)

. Abused sexually by parent?	Y	N	Mother	Father
. Abused sexually by non-parent?	Y	N	Male	Female
. Abused Physically by parent?	Y	N	Mother	Father
. Abused Physically by non-parent?	Y	N	Male	Female
. Abused Emotionally by parent?	Y	N	Mother	Father
. Abused Emotionally by non-parent?	Y	N	Male	Female

5X

Background on Instant Offense:

24. Length of Sentence: _____Yrs. Stipulation: Y N: Length:_____
25. Type: (Circle one): Trial Plea Bargain
26. Original Charges:_____

_____

_____

27. Final Charges (if different):_____

_____

_____

28. Number of victims in Instant Offense:_____
29. Age(s):_____
30. Gender(s):_____
31. Relationship(s):_____

_____

_____

32. Anything unusual about offense:_____

_____

_____

Therapeutic Factors

33. Inpatient Treatment Participation: (Circle applicable numbers)
    (1) Refused to participate in therapy (TR-Therapy Refusal)
    (2) Primary Group Only
    (3) Primary + Neutral (or 2nd opinion) Group Only
    (4) Primary + Ancillary Group Only
    (5) Primary + Neutral (or 2nd opinion) + Ancillary
34. Substance Abuse (circle one) Y N
35. Alcohol Abuse (circle one) Y N
36. Participation In Para-Pro? Y N How many?_____
37. Participation In Education? Y N Specify (use separate sheet if necessary)_____
38. Therapy Attendance record: (circle number that applies)
    (1) No Attendance (2) Sporadic Attendance (3) Regular Attendance
39. Quality of Therapy Participation: (circle applicable numbers)
    (1) Limited to no Personal Work/Growth
    (2) Some Progress
    (3) Significant Progress; Still Unresolved Problems
    (4) Marked Resolution and Change

6X

. Progress in Parole Process: (circle applicable numbers)
(1) Never made PDS I
(2) PDS I - - - - - - Passed Failed (circle one)
(3) PDS II - - - - - Passed Failed (circle one)
(4) SCRB - - - - - - Passed Failed (circle one)
(5) Parole Board - - Passed Failed (circle one)

. Participation in After-care Treatment: Y N

. Work reports: (circle one) (1) Excellent (2) Satisfactory (3) Poor

. Institutional charges: Y N How many? _____

Number of charges in last 2 years:_____

Type/Sanction:_____

_____

_____

_____

Any other remarks about institutional offenses while incarcerated at A.D.T.C., or about the offender himself: (Use Separate sheet if necessary)_____

_____

_____

_____

_____

rmation on Prior Criminal History (Use separate sheet if necessary)

	Date of Arrest	Type of Charge	Dates of Incarceration	Sexual/ Non-Sexual
1)				
2)				
3)				
4)				
5)				
)				
)				
)				
)				
)				

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44. Total # of arrests for sex crimes: _____
45. Total # of convictions of sex crimes: _____
46. Total # of incarcerations for sex crimes: _____
47. Total # of years incarcerated for sex crimes: _____
48. Total # of arrests for Non-Sex crimes: _____
49. Total # of convictions for Non-Sex crimes: _____
50. Total # of incarcerations for Non-Sex crimes: _____
51. Total # of years incarcerated for Non-Sex crimes: _____
52. Total terms of Probation: _____
    Parole: _____
53. Total # of Parole violations: _____
54. Total # of victims of sex offenses: _____
55. Victim information (prior offenses)

Age	Gender (M/F)	Relationship

. Total # of arrests for sex crimes: _____

. Total # of convictions of sex crimes: _____

. Total # of incarcerations for sex crimes: _____

. Total # of years incarcerated for sex crimes: _____

. Total # of arrests for Non-Sex crimes: _____

. Total # of convictions for Non-Sex crimes: _____

. Total # of incarcerations for Non-Sex crimes: _____

. Total # of years incarcerated for Non-Sex crimes: _____

. Total terms of Probation: _____

Parole: _____

. Total # of Parole violations: _____

. Total # of victims of sex offenses: _____

. Victim information (prior offenses)

Age Gender (M/F) Relationship

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

Recidivism Offense Information

56. Length of time between release and re-offense (months)_____

57. New arrests for Sex-Related Crimes (by year)

58. New arrests for Non-Sex-Related Crimes (by year)

59. New Convictions for Sex-Related Crimes (by year)

60. New Convictions of Non-Sex-Related Crimes (by year)

61. Offenses Committed While On/Not-on Parole (by year)

10X

. Number of victims for Recidivism Offenses: _____

Age	Gender (M/F)	Relationship

. Disposition of Recidivism Offense(s)

(1) Release (2) Reincarceration at A.D.T.C

(3) Reincarceration Elsewhere (4) Probation

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PUBLIC NOTIFICATION OF SEX OFFENDER RELEASE

The following document was prepared by the Safer Society Program regarding the issue of public notification of convicted sex offender release to the community. It does not represent the views or opinions of any other organization or group, professional or otherwise. The Safer Society advocates for community safety, victim restitution and treatment, and quality comprehensive sex offender treatment. While the Safer Society supports adult sex offender ***registration*** laws in general, it is totally opposed to ***public notification laws***. This document is designed to assist states considering public notification to explore related issues and the impact of public notification on the greater community, including citizens, families, victims, and offenders. *Numbers preceding the following paragraphs do NOT indicate relative importance, but are used for ease of reference.*

1) **CONSTITUTIONAL RIGHTS** - There is considerable legal debate concerning the constitutionality of public notification laws and an individual's right to privacy. Courts in five states—AK, AZ, CA, IL, and NH—have struck down public notification laws as unconstitutional.

2) **ORIGINS OF PUBLIC NOTIFICATION** - The efforts in most states where public notification laws have been proposed have been the result of public reaction to a horrific crime. Usually these crimes have been rape-murders. The vast majority of sex offenses do not involve murder of the victims. Rape-murders account for less than 3% of all committed sexual offenses. These sensationalized cases make national news and give the public the false impression that rape-murders are more common than they are in reality.

3) **CONFIDENTIALITY**- The sexual abuse of children falls under a diagnostic category in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition) known as pedophilia. Public notification laws require that a mental health/medical diagnosis be made public. Yet, despite their criminal, negligent, and frequently deadly behavior, drunk drivers (a high percentage of whom are suffering from alcoholism) are not routinely required to notify potential passengers of their criminal histories. While public health professionals must be notified and appropriate treatment begun, persons diagnosed with tuberculosis (a highly contagious and potentially deadly disease) are not required to post quarantine signs. Where shall we draw the line? Should we notify the public about *all* persons with diagnoses that render them dangerous to others (i.e. persons with diseases such as cholera, rubella, and other communicable medical disorders, mental health diagnoses such as psychopathic personality, etc.)?

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[continued]

4) **PRIMARY PREVENTION** - The best way to stop sexual abuse is to prevent it before it begins. Public notification laws are tertiary prevention efforts, and any public health official will confirm that primary prevention is much less costly and more effective than tertiary prevention. While public notification may contribute to lowering the reoffense rate of some convicted sex offenders, it will do very little to prevent undetected sex abusers (the majority of offenders) from sexually abusing others and making more severe threats to victims in order to decrease the chance of being reported. Public notification will require a considerable amount of public funds that might be better utilized in primary prevention and offender treatment programs.

5) **PUBLIC NOTIFICATION WILL COST AN INCREASING AMOUNT OF PUBLIC FUNDS TO IMPLEMENT AND MAINTAIN** - To make public notification work will require continuous monitoring by public service agencies (police, courts, probation and parole, etc.) to ensure offender compliance. A team of professionals will need to continuously validate phone numbers and addresses given by offenders as well as changes of address. These same professionals will be responsible for notifying the schools, churches, neighborhoods, etc. about new offenders in the system as well as updating these groups about changes when offenders already in the system move. Public notification may not be cost-effective compared to other prevention efforts, especially comprehensive, specialized treatment. Public harassment of sex offenders may result in their moving to neighborhoods that are less able to attend to their potential reoffending.

6) **FALSE SENSE OF SECURITY** - Public notification is a quick fix to a highly emotional issue, sexual offending. Edward Martone, Executive Director of the American Civil Liberties Union of New Jersey notes that New Jersey's recent passage of a public notification law is "more symbolic than substantial." Public notification may soothe local fears but will not stop the known offender who wants to reoffend from going to a neighboring community where the public does not know him and selecting a victim.

7) **LACK OF SUPPORTING DATA DETERMINING THE EFFICACY OF PUBLIC NOTIFICATION** - No scientific evidence are available from states with public notification laws to support the efficacy of such laws in promoting community protection and safety, and no one is currently gathering such evidence. However, there *are* data and evidence that maintaining specially trained parole officers reduces the possibility for reoffenses after treatment.

8) **EXTENSION TO OTHER CRIMES** - Why single out sexual offenders? If the public is concerned about dangerous offenders and crime, why not notify the public about the release of *all* offenders who physically assault others, murderers, offenders who deal drugs, and other violent criminals?

[continued]

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9) **TERRORIZES THE COMMUNITY** - Public notification will terrorize communities. What will happen when a particular community discovers that it has 10-15 known child sexual abusers living in it? Will its citizens feel more safe? How will this law help you feel when you discover that two sex offenders are living on the same block? How will this fear effect the children of the community when parents feel it is unsafe for them to go out and play? When a property owner wants to sell a house next to a known sex offender, how will the real estate agent convince the prospective buyer that this really is a "nice, safe, neighborhood"?

10) **IMPACT ON VICTIMS** - Public notification affects more than just the offender. While the *victims* of sexual abuse (along with victims of other violent crimes) *should* be notified when the offender is released, the public at large should *not*. When the case is public and the victim is known, public notification will draw attention to the victims as well. What should we tell a 13-year-old child who has been sexually abused and is concerned because the offender's name and the case are being discussed all over town? How should the community help this child respond to being taunted, labeled, and shunned by other children in school? What impact would public notification have on the child victim of incest when the offending parent is released?

11) **IMPACT ON OTHERS** - The impact of public notification goes well beyond the offender, and in some cases, even beyond the victim. Highly publicized cases have an impact on the victim's family and the offender's family. Is it fair to have people stare at and gossip about them because they are married to a sex offender, the sister, brother, parent, or relative of a sex offender or the victim of a sexual offense? Public notification begins to affect the rights and privacy of others in negative ways.

12) **RISK DETERMINATION** - States such as New Jersey have established levels of public notification based on a determination of the risk and dangerousness of the particular offender in question. However, risk assessments may be conducted by untrained persons using a standardized list of risk criteria. In the absence of highly qualified, trained professionals to conduct comprehensive risk assessments, the chance of miscalculated risks, up or down, is increased. Harassment of a sex offender as a result of public notification increases the offender's level of stress and raises his risk of reoffending, a factor which may invalidate pre-release risk assessment procedures.

13) **PLEA BARGAINS** - Sometimes sex offense cases are weak in evidence resulting in plea bargains to lesser offenses (assault vs. rape, contributing to the delinquency of a minor vs. child sexual abuse, for example). Offenders who plea-bargain down their charges may be equally dangerous or more dangerous than other convicted sex offenders. Public notification will not be applicable to these offenders.

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14) **EXTERNAL CONTROL vs. INTERNAL CONTROL** - Getting tough on crime, the death penalty, "3 strikes you're out" sentencing, etc. are quick-fix emotional responses to serious societal problems. More and more states are enacting tougher laws, including the death penalty, in response to the growth of violent crimes, yet violent crime has not decreased as a result of tougher laws. Sexual abuse is on the rise despite tougher laws and stiffer sanctions. These are *external* measures of controlling criminal behavior. The behavior of an individual is best controlled when the person learns effective *internal* controls to stop the problem behavior. Comprehensive treatment including relapse prevention is the best option in attempting to teach individuals effective means by which they can control their behavior. The scientific literature indicates that comprehensive treatment and specialized supervision are effective ways of reducing recidivism (reoffense).

15) **ADVERSARIAL ROLE / ETHICAL DILEMMA** - Recent research suggests that professionals who treat sex offenders often do not receive professional respect from their colleagues who do not treat or are opposed to treating sex offenders. Public notification may further exacerbate this problem. If sex offender treatment specialists are required to play a role in public notification, it may set up adversarial situations between the sex offender treatment professionals and others. In addition, public notification may put sex offender therapists in a position of violating the confidentiality of their clients (i.e. being required to do risk assessments and disclose the information to the public).

16) **AGE OF THE OFFENDER** - What should be the cut off age for public notification? Does it apply only to adult offenders? Should it apply to a 15-year-old, a 12-year-old? What about abuse-reactive children who are four and five years old and acting out sexually on other children? Should these young children also be subject to public notification? Public notification will negatively impact the normal development of teens and children. Is it right for a 15-year-old to not be provided the opportunity to therapeutically correct the problem, to have legal obstacles be put in the way of having friends, building self-esteem and experiencing normal child/adolescent development?

17) **IQ OF THE OFFENDER** - Some sexual abusers are developmentally disabled and have IQs well below the normal intelligence range. These clients require specialized treatment that is sensitive to their disability. Should these sex offenders be subject to public notification laws? Public notification may interfere with other rights afforded to developmentally disabled persons and may be counter-therapeutic to a condition that is diagnosable and a part of the etiology of the individual's behavior. The increased stress engendered by public reactions to notification heightens the possibility of reoffense.

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18) **FEMALE SEX ABUSERS** - Female sex abusers are being identified in increasing numbers. In many instances they are involved with co-offenders (usually males) and are coerced into the deviant sexual behavior. Some theorists suggest that if the co-offender had not initiated the sex offending behavior, the female offender would not have engaged in sex offending behavior on her own. Should public notification laws be applied to these female sex offenders as well?

19) **MENTALLY ILL SEX OFFENDERS** - A small percentage of sex offenders sexually abuse because they suffer from a biological anomaly or a mental illness. In many cases proper psychiatric care and the use of psychotherapeutic drugs can eliminate the sex offending behavior. Should public notification laws be applied to this group of sex offenders?

20) **UNDERMINES TREATMENT** - The majority of sex offender treatment specialists identify the same problem areas for sex offender clients, including (but not limited to) core problems such as poor anger management skills, fear, lack of trust, low self-esteem, feelings of rejection, inadequate social skills, lack of empathy, isolation from others, and poor communication skills. Public notification will generally result in the offender being ostracized by the community and reinforce if not worsen these problems. Public notification very likely will undermine sex offender treatment and potentially increase an individual's potential to reoffend.

21) **LIMITS THE OFFENDER'S ABILITY TO FUNCTION IN THE COMMUNITY** - If sex offenders are going to learn appropriate skills that assist them in preventing further offenses and functioning appropriately in the community, they are going to require specialized treatment. Public notification will limit the offender's ability to properly function in the community, which will in turn have a negative impact on their involvement in treatment. The potential to be ostracized will result in many offenders despairing of ever living normally or being accepted in the community. Such hopelessness produces an apathy towards both treatment and attempts to conform with community morals and values. That is, even offenders who are highly motivated to get treatment and who *want* to learn how to change their behavior very likely will think, "Why bother? No matter how hard I work to manage my behavior and not hurt anyone, people will reject me, put me down, ostracize me, etc." Public notification is a "scarlet letter."

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22) **MISPLACED RESPONSIBILITY** - Public notification places the responsibility of safety and individual appropriate conduct on the community, not on the offender. Treatment is most effective when offenders are required to take total responsibility for their behavior. Comprehensive programs using Relapse Prevention techniques emphasize the *offender's* responsibility to notify persons in his support system of his offending behaviors, patterns, and risk factors for reoffense. Persons to be notified by a supervised offender in such programs include (but are not limited to): landlord, employer, family, friends, etc. Each of these persons assists the therapist and probation/parole officer in monitoring the offender's behavior by reporting any problems. This INFORMAL (nonstatutory) notification by the offender places responsibility *on the offender* to establish a high level of monitoring of his behavior in the community when any sign of difficulty or problem arises. STATUTORY public notification gives that responsibility to the community, whereas it should be shared by the offender.

23) **SUBSEQUENT VIOLENCE** - Public notification may lead to further violence. Some states have already experienced vigilante activities such as the homes of known sex offenders being set on fire or persons being beaten.

Careful thought must be given to the long-term impacts of proposed public notification legislation. The bottom-line question is whether such legislation is based on the *facts* of how best to prevent reoffending or on assuaging *feelings* of revenge.

We welcome feedback. Please direct comments and enquiries to The Safer Society Program, PO Box 340, Brandon, VT 05733-0340.

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Remarks of Craig L. Conway to Joint Legislative Task Force Re: A.D.T.C. 2/1/95:

Good Afternoon, my name is Craig L. Conway and I am currently a treatment staff member at the ADTC. I hold a Masters Degree in Counseling Psychology from Rider University and am certified by the State Board of Social Work Examiners as a Social Worker. In addition to my position with the Department of Corrections, I own a private counseling practice and teach on the campus of Rider University. I am extremely involved in many professional organizations in addition to attending and speaking at a variety of trainings within the field of mental health. I have studied in depth the field of sex offender treatment over the course of my employ with the Department of Corrections and am comfortable with my level of expertise in this area. I guess I am one of the staff at ADTC who breaks the media's characterization of us as, "..unqualified staff.."

I further break the media's picture of a state worker. I am extremely dedicated to my professional responsibilities to the State of New Jersey and spend many hours of my own time engaged in activities that directly relate to my workplace. I work many hours overtime and rarely spend any of my worktime idle. This is for good reason though. I am dedicated to the treatment of sex offenders, having been a victim of childhood sexual abuse myself. Additionally, I am a resident of Hamilton Township, New Jersey and have a god daughter who plays just one backyard away from the house that Megan Kanka was recently brutalized and murdered in by convicted sex offender, Jesse Timmendequas. I am extremely commited to the safety of the public and am in favor of any laws and treatment that are means to achieving the end that no human being be subjected to the horrendous acts suffered by Megan and the Kanka family. However, I do not feel that the recent legislation or changes to the treatment program at ADTC will meet those ends.

Prior to commenting further, I feel that this task force should know that even through my commitment, expertise, and willingness to go above and beyond what is expected of me for my job, I am not a , "..fair-haired staff member.." in the eyes of the Administration of ADTC or the Department of Corrections. In fact, I have been called a trouble-maker and whistle-blower due to my lack of loyalty to the good ole boy network that exists in the Department of Corrections. I am a statewide officer for CWA Local 1040 and hold the position of Deputy Director of the Gay Officers Action League. I have spoken out against many rights violations and engaged in litigation against the institution as well as the Department. I am the only openly gay treatment staff member at ADTC where the Superintendent himself has publically stated that over 50% of the inmate population is homosexual, but still I am subjected to violations of the discrimination laws of this State. My testifying before you today is seen by the powers-that-be in Corrections as disloyal and hasbeen subjected to numerous attempts to block this testimony from occuring. You need to be aware that the staff members who speak to you today are risking their livelihoods, their jobs, their homes, etc., in the interest of public safety and real, effective changes being made to a system that is inadequate and compromising to the public safety as evidenced by recent events. I tell you this so that when our remarks are written off by the Department, you will understand why.

You have already heard about instances of mismanagement of the ADTC, e.g.-staff members sexual involvement with inmates and the failure to hold those staff members legally accountable for their actions. There are so many day-to-day examples of mismanagement, we would need another hearing to outline them. The consequence of the Correctional mismanagement of a treatment facility is the breakdown of effective treatment. Many programs that might be effective are squashed by an administration that does not understand the impact of their decisions. The ADTC is so top-heavy with Administrative staff that I am surprised it took this long for the facility to fall on it's face. Amongst this administrative staff is not one person who is credentialed in the field of sex offender treatment. Those staff members that are credentialed work daily treating the inmates are grossly underpaid and are expected to work in a hostile work environment. We endure poor working conditions and are overburdened by unmanageable caseloads. We are supervised by staff that are unqualified to supervise us. This creates extremely low morale and assures that the staff's optimal performance level is not reached. The first change that needs to occur is the administration of the facilty needs to come from a backround of treatment so that philosophically the facility can be treatment -oriented. Secondly,

we are understaffed on the line. We need more indians and less chiefs. Obviously for this to occur, positions that are meant to be filled on the front line can not be utilized to hire or rehire political hacks or more management employees as has previously been done at ADTC. The facility's administration should be monitored periodically to ensure that the mission of the facility is being worked toward.

Recently, the Department of Corrections hired a consultant, Dr. Steele, to review the ADTC program and make recommendations for revisions. To accomplish this, Dr. Steele spoke at length to the treatment staff. I personally spoke to her for hours and made recommendations that were included in her report to the Department. This report has been held as confidential from the treatment staff at ADTC. The resulting program revisions have totally lost the spirit of the programmatic changes that were recommended by Dr. Steele and the treatment staff. We have taken a total treatment program and rather than maintaining the parts that were working and fixing the parts that didn't, the baby was thown out with the bathwater. This was done in an effort for the Administration to be able to say, "We revised the program." The new program that was implemented this past Monday on a mandate from the ADTC's Superintendent is poorly-organized, lacks accountability, and in all likelihood will be much less-effective than the inadequate program that previously existed. We now have a program that was so hastily slapped together to appease some political mandate that the likelihood of it having any effectiveness is sincerely questioned by anyone who has any knowledge about the treatment of sex offenders. I personally worked both Saturday and Sunday of this past weekend and discovered a significant number of inmates on my caseload were either never assigned to any treatment module or their actual number of staff contact treatment hours were cut from in some cases 15 therapy-hours per week to what works out to 25 minutes per week having only one group per month. These types of problems when articulated to the people who have the decision-making authority at ADTC are written off and the staff that cares enough to speak out against them are publically humiliated by the same administrative staff who are mandating that the program go into effect prior to it's completion by the treatment staff. Inmates and staff alike are in a whirlwind, not knowing what to do next.

Our new program was supposed to be designed to administer pre and post tests to measure the effectiveness of each module. Most of the modules that were begun this week have no such tests because they were never ordered. The modules that do have assessment instruments are utilizing instruments that in most cases have never been tested for validity or reliability. In short, the program currently in effect will do nothing more and in some cases will actually do less to assess the treatment program or the inmates potential risk to the public upon release. We are currently losing the value of a therapeutic relationship between an inmate in treatment and his therapist by not continuing traditional therapy groups along with the modular program. Some of the modules are extremely needed but will do nothing to effect real change in the inmate if not paired with therapy that will foster integration of concepts into his person. We need to be able to teach skills as well as measure the level of the inmates ability to integrate and utilize them to control his repetitive and compulsive behavior. We need to be able to motivate individuals into treatment by initially extremally rewarding their efforts and moving to an internal system of reinforcing behavior. This is not being accomplished with the policies being administered by the ADTC and the DOC today. We have intellectually-challenged inmates that have no understandable programs available to them. We have monolingual inmates that have no bilingual and bicultural psychologist to provide therapy for them. In short, there are many, many changes that need to occur in order for the treatment program to be effective. To accomplish these changes, a team of qualified treatment professionals need to be allowed to take the time needed to make the changes, have the decision-making authority to effect the changes, and be allocated the resources needed to do so.

We now have laws that make a mockery out of treatment by publicizing a treated individuals release, creating public outrage and making it impossible for an individual to reintegrate into society. This reverses any rehabilitation that may have occurred.

From the perspective of what the legislature can do to facillitate changing this, I would suggest:

1. Placing a temporary injunction on the current treatment program of ADTC.

2. Allocating necessary resources, i.e.- budget money directly to treatment and monitor that money so that it actually is used for hands-on treatment.

3. Rescind laws that create public hysteria and make it impossible for an individual to reintegrate into the community. These laws additionally create a false sense of security to the community.

4. Establish laws that will provide for lifetime monitoring of sex offenders through registration and specialized parole officers that are qualified to assess an individual's needs in the community to control their behavior.

5. Provide resources for aftercare treatment of these individuals in the community after their release while being monitored.

6. Establish a committee of qualified professionals to consistently monitor the accountability of the treatment program and this system.

In short, we need to provide an effective continuum of care for sex offenders that might include an initial punitive sentence in the prison system, followed by mandatory inpatient treatment accomplished by indeterminate sentencing, followed by outpatient treatment in the community monitored by specialized parole officers/treatment professionals, followed by lifetime monitoring through registration and periodic evaluation of these individuals. Educational programming and counseling services additionally should be made available in our public school systems regarding how not to become a victim of this type of crime. Research needs to be done to establish assessment and treatment of high-risk youth to slow/stop the rate of new offenders being produced.

These are monumental tasks I know and I applaud your willingness to begin to sift through this out-of-control system. I only hope that real change is mandated and the public safety not continue to be compromised by political rhetoric. I am willing to expand on any of my ideas and work further with any member of this task force that would like further information or suggestions for improvement of this system. Thank You for your time.

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Good Afternoon. My name is Suzanne Beshak and I have held the position of Substance Abuse Counselor at the ADTC since December of 1986. I have Bachelors Degrees in Psychology and Criminology from Rutger's University and have fulfilled the necessary education and work requirements for my Certification in Alcohol and Drug Counselling (CADC), which I expect to receive this spring. With my education and experience, and with the help of my co-counselor for the past four years, I have developed and implemented the substance abuse program at Avenel. It is the most comprehensive program in terms of amount and variety of groups being offered at any correctional facility in New Jersey.

During the past several months, I have served on our Treatment Program Revision Committee and worked to modify the substance abuse program to conform to the new sixteen-week module system. However, rather than cover ground already covered by my colleagues, I will simply support them in a few key areas.

First, I agree that the new program with it's time constraints hinders both the therapeutic process and elements of trust and rapport that must evolve in any therapeutic relationship between clinician and client. I feel that inmates have been haphazardly placed in groups with little attention paid to therapeutic need, progress, or outcome. Frankly, the new module system reminds me of a college admissions board wherein advisors are scrambling to make sure everyone has some class or other to attend merely to round out a schedule and fulfill credit requirements. I see little care given to course content, staff training, and overall impact and effectiveness.

In terms of substance abuse, we are severely lacking in adequate funds for professional materials, training, and time to focus specifically on substance abuse treatment. We currently have just two counselors on staff to serve a population of 740 men. Other institutions have (and rightly so) funded, focused, segregated programs with larger staffs dedicated specifically to an identified substance abuse population. At Avenel, our efforts are diffused due to disorganization and addicted inmates being scattered throughout the facility.

Furthermore, statistics provided by the Bureau of Community and Professional Services in Trenton show that in excess of 70% of our inmates struggle with chemical addictions while only 2% are presently enrolled in a counselling group. Another 5% are involved in substance abuse education classes. I would estimate then, that an approximately 7% or 50 out of a possible 520 who need substance abuse education and counselling are receiving it this semester.

At this juncture, I would like to turn my focus to issues that are of even deeper concern to me. I'm speaking of the pre-release and post-release process for sex offenders. First, allow me to address the two points I believe we can all agree on:

1. All of us here today are deeply disturbed by the cruel, despicable victimizations of Megan Kanka, Amanda Wengert and countless other victims.

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2. We would all like to prevent such victimizations from ever recurring, and do so, as quickly, efficiently, and cost-effectively as possible.

The questions we need to be asking ourselves are:

1. What are the best methods of achieving these goals; and
2. What can we as treatment professionals, legislators, concerned citizens and taxpayers do to ensure the unlikelihood of any more victims?

The facts are that offenders preparing for release from Avenel need housing, employment, emotional support from family and friends, financial assistance in some cases, fairness within the justice system, and aftercare treatment in order to become responsible, productive members of society. Some offenders have all of these basics in place. Some possess a few. Some don't have any. I want to challenge you at this moment and ask..."If you were a released sex offender venturing out into the climate that exists today, and had no housing, no promise of employment, little emotional support, a vascillating justice system, and no aftercare treatment made available to you, where would you go, and what would you do?"

Please understand that I'm not asking for sympathy for these men. I am, however, identifying real concerns that affect all of us, potential victims and sex offenders as well. I believe that Megan's Law is an attempt to take control and secure the safety of women and children in our state. But, I submit to you that with all its good intentions, it falls very short of the mark. My aim is not to debate Megan's Law, but to discuss what other steps need to be taken to prevent any more victims. Let's begin with aftercare treatment.

Aftercare or outpatient treatment is a common practice among most therapeutically based treatment centers. It's a critical component in helping a former patient make the transition from a structured environment back into family life and society. Avenel does offer a limited amount of aftercare to address the problem of sexual compulsivity. However, after three attempts at proposing aftercare for substance abuse issues, my requests were repeatedly denied by our administration. Even though I committeed myself to taking full responsibility for the program and adjusting my schedule accordingly, my recommendation was met with disinterest. I argued the necessity of this program, pointing out parole violations due to drug use, reports of other ex-inmates using drugs, and inmates not yet released expressing fears of relapse if the pressures were too great on the outside. It stands to reason that if an ex-offender begins to drink or use drugs again, the chances of his recommitting a sex crime are great.

I was reminded that we do provide referrals to treatment centers and 12-step programs on the oustide, but I further argued that an ex-offender needs the freedom to discuss his alcohol or drug problem in tandem with the pressures and fears of also being a recently released sex offender. I can tell you honestly that such discourse would not be well received in any AA meeting I've ever attended. So, I appeal to your common sense. If we are spending thousands of dollars, annually per inmate for in-house treatment, why not take a nominal percentage of those funds and apply them to necessary aftercare treatment.

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I'm also concerned about immediate housing for former offenders. With the new registration laws requiring an inmate to provide an address 90 days prior to release, many are unsure of where they are headed. Just last week four men came into my office who had addresses, but lost those privileges due to their family's perceived risks associated with notification. For all intents and purposes, these men will be homeless until alternative housing can be found. For this reason, I am strongly advocating halfway housing for sex offenders; a place where they can live temporarily and be monitored as they adjust to living in society.

Released offenders also need security and acceptance in public housing domains and the job world. In order to achieve these goals, fairness within the justice system needs to be more clearly defined and maintained. The three tier classification system to assess risk of a released offender is a functional and applicable idea. Unfortunately, this process has been removed from the hands of competent treatment professionals who have expertise in these matters and left to the discretion of county prosecutors. I can appreciate and respect the level of fear, anger, and yes, even inclincation for revenge against these perpetrators. Yet, in our haste, are we not adding fuel to a fire already raging out of control? Logically, if we create an environment wherein it's virtually impossible for the offender to reacclimate, know that his chances of recommitting a sex crime are even greater.

Specialized parole officers for sex offenders and indeterminant sentencing are also constructive ideas. Again, you are placing the burden of responsibility with professionals who have been trained in these matters. Also, considering the mismanagement of the system as it exists today, be aware that many offenders are seeking refuge in other states where notification laws are less strict or don't exist at all. That is not Avenel's policy, but, I must admit that in some cases, I am encouraging that inmates do just that. Then, I wonder how fair that suggestion is to our neighboring states.

In conclusion, I implore you to take time and consider the grave realities of the situations we are facing. With Megan's Law in place, please recognize the additional steps, and yes, tax dollars that may need to be spent in order to truly provide safer communities for our vulnerable citizens. Realize the inherent dangers of applying too much pressure and extending no support to sex offenders whose futures are uncertain and unstable. Let's not kid ourselves and believe that by knowing where a sex offender lives or works that we can control his behavior. Instead, let's generate treatment and support that will help him to remain healthy and on a path to recovery. Let's put our emotions aside for now and think clearly and objectively about what tactics and strategies will affect real change. Let's truly put a potential victim's interests first, and boldly bring this chaotic situation under control.

Suzanne Beshak
Substance Abuse Counselor
ADTC, Avenel, NJ

ADULT DIAGNOSTIC & TREATMENT CENTER
AVENEL, NEW JERSEY

INTEROFFICE COMMUNICATION

TO: Grace Rogers
Assistant Superintendent

FROM: Suzanne Beshak, Substance Abuse Counselor
thru Donna Klipper, Director of Social Services

DATE: April 29, 1994

RE: Proposal for an Aftercare Program to Address Substance Abuse Issues

I am proposing that an Aftercare group to address substance abuse related issues be formed for ex-inmates whom have either paroled from or reached their maximum date of incarceration at the ADTC. More than 70% of these inmates have abused substances. Consequently, the high rate of relapse back into drug and alcohol abuse among such individuals will inevitably negate their therapeutic progress previously realized.

This group would run similarly to the aftercare group already in existence, which provides therapeutic intervention for issues of sexual compulsivity. There is a great need for such a group based on parole violations due to substance abuse. Reports of other ex-inmates abusing substances as well as the fears of relapsing expressed by inmates who are due to be released. This group would give ex-inmates in recovery an opportunity to share their struggles with being tempted to drink or use again in their daily lives on the street. Although we're already providing referrals for community-based treatment centers and self-help programs, an aftercare group would encompass the unique circumstances of readjusting to living in society with substance abuse issues as a sex offender.

This would be a pilot project that I would assume responsibility for, provided that voluntary membership would include a minimum of ten participants If, after a reasonable period of time there appeared to be a lack of interest, the group would be disbanded. This group would run once-a-week from 6:00pm-8:00pm on Thursday evenings in the Fronthouse Boardroom. Members would be recruited from referrals received from treatment staff, substance abuse, and the primary aftercare group already in existence. Thank you for your consideration of this matter.

c: Miss Klipper, DOSS

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