MEETING

of

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

"Testimony regarding the therapy program of the Adult Diagnostic and Treatment Center"

LOCATION: Legislative Office Building
Committee Room 7
Trenton, New Jersey

DATE: March 15, 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 Edward T. O'Connor, Jr.

GENERAL ASSEMBLY:
Assemblyman Stephen A. Mikulak, Chairman
Assemblyman Joseph R. Malone, III
Assemblyman James W. Holzapfel
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
The Office of Legislative Services, Public Information Office
Hearing Unit, State House Annex, CN 068, Trenton, New Jersey 08625

R E V I S E D

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 - March 15, 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, March 15, 1995 at 10:00 AM in Committee Room 7 of the Legislative Office Building, 135 West Hanover Street, Trenton, New Jersey.**

The task force will receive testimony from William Fauver, Commissioner of the Department of Corrections; Nathaniel Pallone, Chairman of the Special Classification Review Board; Rob Freeman-Longo of Safer Society; and the American Psychiatric Association. The task force also will accept testimony from the public.

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Assistive listening devices available upon 24 hours prior notice to the committee aide(s) listed above

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SENATOR C. LOUIS BASSANO (Senate Chairman): Will everyone be seated so we can get started?

Anne, if you will do a roll call so we know who is present?

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

MR. THOMAS: Here.

MS. STEFANE: Mr. Muller?

MR. MULLER: Here.

MS. STEFANE: Professor Brooks?

DR. BROOKS: Here.

MS. STEFANE: Assemblyman Zisa?

ASSEMBLYMAN ZISA: Here.

MS. STEFANE: Assemblywoman Turner?

ASSEMBLYWOMAN TURNER: Here.

MS. STEFANE: Assemblyman Holzapfel?

ASSEMBLYMAN HOLZAPFEL: Here.

MS. STEFANE: Assemblyman Malone?

ASSEMBLYMAN MALONE: Here.

MS. STEFANE: Assemblyman Mikulak?

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

MS. STEFANE: Senator O'Connor?

SENATOR O'CONNOR: Here.

MS. STEFANE: Senator Inverso?

SENATOR INVERSO: Here.

MS. STEFANE: Senator Bassano?

SENATOR BASSANO: Here.

MS. STEFANE: We have a quorum.

SENATOR BASSANO: Thank you.

I'm hopeful that this will be the last general meeting of this Joint Legislative Task Force, and the next time we meet we can start to put together our report. In fact, I didn't envision us going as long as we have already on this subject.

It seems that the more information we find out the more complex the issue becomes.

We've asked the Commissioner of Corrections, Commissioner Fauver, to be with us today.

Commissioner, do you want to introduce yourself?

But before we do that, I know that my Cochairperson here has a few words he wants to say, and then we'll turn it over to you.

ASSEMBLYMAN MIKULAK: Thank you, Senator.

As we close out our fourth and final hearing of this Task Force, I just want to take the opportunity to make a few observations.

First, I want to thank my Cochair, Senator Lou Bassano, and all the other members of the Task Force for their time, their professionalism, and their commitment to the cause.

When we began these hearings three months ago, we really weren't sure what to expect. We didn't know much about Avenel or its administration. We knew even less about its treatment programs or about how successful they had been in rehabilitating inmates.

What we did know was there were a couple of high-profile cases involving little girls who were raped and killed by their neighbors, each of whom had been convicted of sexual assault in the past and each of whom had reportedly been treated. One is a juvenile and one is an adult.

With that in mind, we set out to study Avenel and to determine whether the treatment there was working. What was surprising to us was the way in which we were almost immediately treated as adversaries, both by the administration at Avenel and the Department of Corrections. We were not on a witch hunt. We did not convene this Task Force to try to shut Avenel down, but that is the way we were treated.

When we asked for percentages of inmates who were rearrested after release, we were given two completely different

sets of numbers. One set, from the Department of Corrections, put the rate at about 45 percent. The second set, by the staff at Avenel, cut the number to 18 percent. Janet Reno, our U.S. Attorney General, has put the rate of rearrest even higher, between 40 percent and 70 percent for violent sex offenders.

As if that was not enough, we were attempting to study the treatment programs at Avenel, and that program was changed in midstream. A conscious decision was made by the administration at Avenel and the Department of Corrections. The fact is, there is no conclusive evidence to prove that deviant sexual behavior can be treated. That idea is more a product of faith in government as medicine man and not any scientific study.

Right now, as we speak, two states, California and Virginia, have completely cut their sex offender programs back citing the lack of any proof that sex offenders can be cured. In fact, the figures out of California show that the rate of rearrest for sex offenders actually rose by 15 percent during the last year of this program.

While I'm not prepared to close the doors on Avenel, I am prepared to support some significant changes. I think there is a general consensus among members of the Task Force that sex offenders in New Jersey serve too little time in prison.

Even the Federal judge who recently declared Megan's Law unconstitutional -- or parts of Megan's Law -- has recommended, "If you are convicted of a sex crime against a child, you should spend the rest of your life in prison, or if you are released, you should be subject to continual probation for the rest of your life."

In that regard, I would support a return, which we've discussed here on this Task Force, to the 30-year indeterminate term for violent sex offenders. If you refuse treatment, you should be automatically sent back to the general prison

population, knowing full well that you will serve the maximum amount of time under the law and you will not be paroled.

As it stands now, our current system rewards those inmates who refuse therapy and their return to the main population, by paroling them sooner than if they had remained at Avenel. That is ludicrous. We need to make sentencing more consistent. No matter where an inmate is housed, his term should remain the same.

I also feel that we need to refocus our efforts and consider the victims. There should be intensive therapy available to the victims and their families. The perpetrators should be the ones to pay, if that is at all possible.

While touring Avenel, we were appalled that almost every inmate had their own television, their own radio, and their own computer. That practice has to stop. All the money wasted on inmate amenities should be redirected to the victims' recovery.

In conclusion, I want to thank everyone who testified at these hearings. I look forward to working with the Task Force in gathering our final recommendations.

Thank you.

SENATOR BASSANO: Thank you, Steve.

I think, Commissioner, you received a very brief overview as to the direction that this Task Force is going and some of the recommendations that we're going to be making. I think the areas that Steve touched on are a couple of areas where you're going to see a unanimous position from this particular Task Force. But, hopefully, we're going to go a lot deeper into this subject than was just mentioned.

As I said earlier, I'm hopeful that somewhere around the 17th of April we can gather as a Task Force, work from an outline, put together a draft of some suggested changes, and then present that to the public.

But before we do that, we do want to hear from you, and we do want to hear from several other speakers who are going to be addressing us. I know I have a list of questions that I would like to have answered. I am sure many of the other members of the Task Force, likewise, have some questions they want answered. So without going any further, why don't we allow you to start your presentation?

COMMISSIONER WILLIAM H. FAUVER: Thank you, Mr. Chairman.

First, I'd like to comment on the issue that I know, from reading through the transcripts and what I've seen in the press-- On the issue of the programs being changed, as was said, in "midstream," if there is-- This Task Force should have been notified of that, and I'll take responsibility for not doing that. But I would like to point out that this emanated-- This whole idea of the change came from the staff at Avenel back into late '93, from meetings that were held there.

They then proceeded to go ahead through my office and get a grant to bring in an expert from the National Institution of Corrections to make recommendations. Some of these things-- One of the recommendations is what we saw put into place in December. The timing of that coincided with the Task Force, but the decision to do that, really, was-- The final decision was sometime in December or late November, but the recommendation predated even the formation of the Task Force.

I would hope that in conjunction with you, we can make changes to make Avenel more viable. Avenel or any other prison in this State, or any other state, is not where, ideally, it should be or what should be happening in those places. We are agents of the law, and whatever the law is and however that is set up, that is what we'll do. That is how we will treat people, whatever that might be.

One of the things that has happened already, which I think is a big help, is the fact that if a person does not

participate in therapy, and they go back to the prison, or if they're there, they do not get credits. They do not get good-time credits. They do not get work credits. I think that in itself is an incentive to get more people into therapy programs.

I think you could debate, and it is debated, should a person be transferred out of there right away? My personal opinion on that is, no. I think one of our responsibilities is to try first to get that person involved. There has got to be some point where you say, "No. He's refusing, he's refusing. We have to use this space for somebody else who is more amenable to treatment and bring them in." So I would agree with the Assemblyman on that as far as having to move people out of that institution.

Remember, Avenel, when it was built -- when it was started about 20 years ago -- was constructed for less than 200 inmates. That was a plus because the number coming over for mental health at the time, when that was moved -- under the Division of Corrections, then under INA -- there was plenty of leeway. There were 50 extra beds. Obviously, when we look at 700 people today, we know that that turned out not to be true.

A number of things have happened. There has been a change not just in programs, there has been a change in the clientele that have arrived there. Generally, in the past when this was first started, what we would see mostly were forcible rapes. There was very little in the way of incestuous people being there, child molestation. With education programs through the schools, through the TV, a lot of these things became known and they were more reported. That part of the population, the type of population, has changed to a great degree.

I think there are things that this Task Force can do, can recommend. One, as I said, is the treatment. Somehow if we can get together and decide a time line on that: If you're not in, you're out, and you're out into a prison.

I think another factor that has to be talked about is when the person is going before the judge, as you are aware, they are sent to Avenel now for a diagnostic workup. That is then given to the court. That, now, may or may not decide that the person is repetitive compulsive. So we turn the report in, it may or may not be accepted. The judge has the ultimate discretion on that.

So we may see people not in Avenel because of that -- they're sentenced under a regular sentence -- who, in the opinion of the therapists, need help. I think we should try to expand into some of the regular prisons to deal with that, even though they're not sentenced under the sex offender statute. Maybe that could be broadened; maybe that could be a separate bill. I don't know.

But I think we're misleading the public in many ways if we say people are being treated. Then they read about somebody getting out of say, Southern State, and they're in for a sex offense, but they're not committed under the sex offender statute. I think that the same kinds of things should happen there as far as maximum sentences and staying in unless you get into therapy, but right now, they are not being treated. I think that kind of ties into some of the truth in sentencing laws that the Legislature has worked on over the last couple of years.

I think that Avenel-- You'll hear people today who are experts. There is somebody coming down from Vermont to talk about the program. I think you'll see there are many different views on what can and cannot work. As far as I know, Avenel is still the only stand-alone facility that is not part of another unit, another prison.

When this was done -- and we're only taking about 20 years ago -- this was the state-of-the-art type of thing that other states came in to look at and follow. I'm not here to sit here and tell you that you can be treated as a sex offender at

Avenel and not at Rahway or not at someplace else. That is obviously possible if we buy the premise at all that the treatment works.

I think that right now we have to keep trying to see where this all sorts out and what happens with it. But I, personally, am not ready to abandon the concept of Avenel, the concept of treatment. I think within parameters-- Because, right now, one of the things that comes across is the overcrowding. You see people idle. You see people not involved in anything, strictly as a point of the overcrowding, not because we don't know what to do. We don't have the ability to do it. That is not just in that prison, it's all over.

So I would hope that between us and others we can, through the experts coming in and hearing their testimony, reach some kind of agreement where we all support the same type of legislation or whatever might be coming down.

But I think it is not unusual to find people, even in the same institution, who disagree with that. All doctors who are medical doctors don't agree on how to treat somebody when they see them. I don't think that is any different than psychologists or psychiatrists not all unanimously agreeing on what should happen. It then becomes the job of administrators to make their best estimate on what we should do.

So having said that, I really would rather allow more time to try to respond to your comments or questions, Senator.

Thank you.

SENATOR BASSANO: I don't think, Commissioner, that this panel possesses the expertise to be able to dictate to the system, to the Department of Corrections, the type of treatment that you should be giving. I think that has to be determined based upon the people you hire at Avenel and the particular theory that those individuals believe in. I think what we're dealing with is a theory, and I'm sure there are a number of

different theories out there. So I don't think we're going to be making that type of recommendation.

Some of the concerns that we have are with regard to people coming out who have not received proper treatment and who are now maxing out. We want to change the system in such a form so that people will only get out through parole, and those people who are deemed not to be dangerous to society will be the only ones that will be let back on the street, with civil commitment for those people who, after 30 years, are still deemed dangerous or potentially dangerous.

But there are a number of other areas that I wanted to address. You started to talk about what is happening in the general prison population with sex offenders. I would like to know if you think it would do the State good to do away with the repetitive compulsive portion of the law and leave the discretion to the judges as to who should be sentenced to a general prison and who should be sentenced to Avenel based upon the recommendations that a judge receives? Would we be better served if we changed the law in that respect?

COMMISSIONER FAUVER: No, not in my opinion. I don't think so. I think that right now the judge has that discretion. I mean, Avenel does the write-up on the person, the diagnostic part, and then the judge can decide whether he or she wants to commit under the statute or not.

SENATOR BASSANO: But am I not correct in stating that a person has to commit the crime more than once, with more than one victim, before they can actually be eligible for Avenel? Yet in some cases, we may be better off recognizing right in the beginning, after the first offense, that a person would be better served by going to Avenel? Right now you can't send them there unless there is, as I said, more than one victim or if it's more than once that they have committed the crime.

COMMISSIONER FAUVER: Yes, you're correct. It could be expanded, I would assume, to do that. There are certain--

If everybody who was in on a sex offense was analyzed in that sense and the judge had the flexibility to put them where they wanted to or where they thought they should, I mean, that is--

SENATOR BASSANO: Can you talk to me about statistics? One of the things that we found in talking to the personnel from Avenel was that no statistics were being kept on recidivism. Why is that not happening? Don't you think that you can't really look at your future when you're not able to judge how successful you were in the past?

COMMISSIONER FAUVER: Well, I think there are statistics kept. I mean, I think what you get into are definitions on recidivism and so forth, is it another offense, another conviction, those kinds of things. We have statistics on people who have been in the system before, who have come back to us that we're aware of. There may be people out of State that we don't know, but the ones in State we do.

So there is I don't know how many, out of between 1000 and 2000, people paroled out of Avenel in its existence-- I don't know sitting here, but we would have a way to know how many of those came back because we have the names and we could trace them.

SENATOR BASSANO: When I questioned Loretta O'Sullivan about that at the first meeting that we had up at Avenel, she said that there were no concrete statistics, that they were guesstimates as to how many people are winding up back in the system. I kind of question why we aren't keeping stronger statistics so that at least we know the direction we're moving in.

COMMISSIONER FAUVER: Well, I think what I'm suggesting is what we would have to do: look at them, actually trace them by name. We don't keep that-- The Department at one point had a research unit, a small unit, but as the budget crunches come, they're the kinds of things that get lost and go. But I think specifically on Avenel, because we're only talking

about -- when I say only -- a 20-year period, we could do that. We would have to do it manually. We don't have a way to computerize it.

SENATOR BASSANO: Let me go on to another subject. The Penal Code of 1978 that we are operating with now, do you think that Penal Code has helped or hurt Avenel in the changes that were made?

COMMISSIONER FAUVER: Well, I'm not sure. I mean it certainly has increased the number of inmates at Avenel, but it has increased inmates in the system. I'm not sure, other than the overcrowded-- I think that hurts because you can't do a lot of the things you want to do. I wouldn't want to suggest that the people who are coming in shouldn't be there. I mean, I think in that sense, both in the general population and at Avenel, they should be.

SENATOR BASSANO: Do you feel that we would be able to utilize some of the prisoners at Avenel the same way we're utilizing prisoners in the general prison population, sending them out on a bus to do community work with an armed guard? That some of them are well enough along in treatment that we can put them out there to clean up highways and clean up vacant lots? Or do you still feel that the position taken by the Department 20 years ago still has to hold, that these people should not be let out to do that kind of work because of an incident that happened 20 years ago?

COMMISSIONER FAUVER: Well, I don't think-- We review our standards for minimum custody, which they would have to be in to go out there, quite regularly. I would not recommend putting them out in that kind of a setting. I think the other groups that we have out on highway details, cleaning shores at the ocean and so forth, are minimum. They're with officers. They're with unarmed officers who have radio contact. They're also very close, within six months, to their parole date.

I think that ideally there should be a place for a sex offender to go before parole if he has gotten a date, he's ready, and you know he is going to go. The aftercare component may not be aftercare; it may just be supervision. But I think that is why we want the people to be on parole as opposed to max out.

Now, as you indicated, if they max out and then there can be a civil commitment, that's okay. But I don't know that that would hold in every case.

To answer you in the first part: No, I don't think they should, whether it's 20 years old or not.

SENATOR BASSANO: You kind of got away from the point I was trying to make. One of the things that this Task Force saw was a lot of idle time. When we're told that a person works two hours a day, an hour a day, and just has a lot of idle time on their hands-- Obviously, some of those people have been there for a while and may be model prisoners. The thought was, could they be put out into the community to do some work, under proper supervision, with a guard? That is the question that was being presented to you. Obviously, if you feel negative about that, then I would like to know that.

COMMISSIONER FAUVER: Yes, I would still feel negative about it. If they were out with an armed guard, I don't think that-- There are people that we have not traditionally, and still don't, put out in minimum custody status; sex offenders are one, arsonists are others, despite where they are in their sentence.

What I'm saying is, I think if there was a place to go, which there isn't right now, before going on parole, as a half-way house kind of a setting, I could see them moving out of the institutional structure to be in a less secure--

SENATOR BASSANO: One of the recommendations that I will make will be the permanent creation of a commission to look at what is happening at Avenel. One of the things that I would

like to charge them with would be to take a look at the development of a halfway house. It is a very volatile issue because no one wants it in their backyard. Maybe the way to go would be to look at some State property -- if we were to get into developing such a halfway house -- as a place to place this type of facility, but that is a little bit down the road.

I'm going to throw the $64 question at you right now. If you had your way and you wanted to improve what is happening at Avenel, what would you tell us, as a Legislature, to do to improve it? If I said to you: What tools do you need? Tell me what you need to make Avenel a better institution with lower recidivism, better treatment, etc.

COMMISSIONER FAUVER: Well, do we have time? The $64 question, by the way, shows your age. That was a long time ago. (laughter)

SENATOR BASSANO: When you came on as Commissioner I was a freshman Assemblyman, if you remember, and we both got old together. (laughter)

COMMISSIONER FAUVER: I think the key on this, basically, would be, I would say, two things: staff and space. I think that we've tried, as I think Bill Plantier and others may have told you at some of the previous hearings. We've freed up positions, but it has been incrementally. We added three psychologists which helps, but is not ideally--

I think staff and the space within the place, or within some place, to treat the-- Because then you can have the full thing. The concept of Avenel in the first place came out of kind of generically, for want of a better word, the ideas of therapeutic communities where everybody there has the same problem. This is done in drug treatment programs, in substance abuse programs, some of the ones in our institutions, and a lot of them outside, on the premise that everybody is together. They go to therapy together. They live together. They work together, the whole thing.

I think that having that, having the opportunities to work, not having the idle time-- I think the kinds of things that you already talked about, making it: "If you don't participate after whatever time line is decided on, you go back and you don't get out."

SENATOR BASSANO: I don't know if that should be our decision or if it would not be better off left with the decision of the personnel from Avenel. Because, as you know, some prisoners will respond faster than others; therefore, you can't put everybody in the same category. Maybe the therapist should make a decision as to whether a person is responding quickly enough, and if they're not, then move them back.

COMMISSIONER FAUVER: Oh, I agree. I agree.

SENATOR BASSANO: I don't know if we possess that type of expertise.

Ratiowise, between prisoners and therapists, what is an ideal ratio? Is there such a thing?

COMMISSIONER FAUVER: I don't know. I would have to ask Bill.

Is there?

WILLIAM F. PLANTIER: They generally agree 1 to 30.

SENATOR BASSANO: What's the ratio now?

MR. PLANTIER: It's 1 to 42, I believe.

SENATOR BASSANO: That is with the new people you put on?

MR. PLANTIER: No, no, Senator, that's not. There is only one new person that started as of this time. There are two others coming on board very shortly.

SENATOR BASSANO: The two new that are coming on, what will that break you down to?

MR. PLANTIER: I haven't done my math, but it will probably get us down to, like, 1 to 35, something like that.

SENATOR BASSANO: So if this Task Force recommended that we try to keep a 1 to 30 or lower than that, obviously would constitute proper funding to do that. But 1 to 30 is where you feel you would have to be in order to give proper treatment?

MR. PLANTIER: No, I wouldn't want to go on the record as saying that is giving proper treatment. I think there is debate among the professional communities. You might hear some people say that it needs to be lower, and you might have other people say that it can be higher. The general number that I have heard throughout the years has been 1 to 30 as being an ideal ratio.

SENATOR BASSANO: Well, if we made a recommendation to the State as to what type of ratio we would like to try to achieve--

MR. PLANTIER: I think you would have struck a middle ground.

SENATOR BASSANO: That is a middle ground?

MR. PLANTIER: I would think so.

SENATOR BASSANO: Okay. I've occupied a lot of time with questions. I know Assemblyman Mikulak has a lot of questions.

So, Steve, why don't you--

ASSEMBLYMAN MIKULAK: Okay. Senator, for the record, there was a Ledger story a few weeks ago about the creation of halfway houses. At that time, I had the Assembly members polled, and I think it was unanimous that that idea was rejected. I think we, in the Assembly, are trying to focus on the actual mandate in the legislation, which is to look into specifically that institution and specifically whether people can or can't be treated and cured, so to speak.

You were polled, everyone was polled? (addressing Assembly members) (affirmative responses) They should be.

SENATOR BASSANO: Polled for what statement?

ASSEMBLYMAN MIKULAK: On the halfway house issue. See, when we saw it in the--

SENATOR BASSANO: I wasn't polled.

ASSEMBLYMAN MIKULAK: No, I'm talking about the Assembly side. I don't think that was a trial balloon that was floated, and I think that that is not going to be a majority recommendation of this Task Force.

SENATOR BASSANO: Well, I intend to make that recommendation.

ASSEMBLYMAN MIKULAK: Right.

SENATOR BASSANO: The reason I will make that recommendation is that the changes that I am going to look for us to make is to have people paroled from Avenel and not have them max out. Before they go out on parole, when they are deemed to be ready for parole, some people, the Parole Board may recommend that they look at a halfway house. I'm not looking at a halfway house in the middle of a sentence of anyone.

I think if you look at a halfway house as being another tool that can be used to help integrate people back into society more safely, that's what it's all about. While Steve and I may disagree on that, I think it is a tool that can be beneficial.

ASSEMBLYMAN MIKULAK: Okay.

To the Commissioner, I recently received a letter from a prisoner in Avenel who is starting a 52-year sentence. I think he won't be eligible until he serves about 20 more years. He was complaining about the lack of therapy. He was only getting an hour a week. He shouldn't be there at all according to-- How do you feel about that?

COMMISSIONER FAUVER: On the longer term sentence people?

ASSEMBLYMAN MIKULAK: Right.

COMMISSIONER FAUVER: I think that ideally, if he is in therapy and he has 30 or 40 years to go, I don't see, really,

a value in that. I think we have to at some point-- The first part of the sentence, if it's a long sentence like that, should be spent in a regular prison and then at some point transferred when he gets closer to eligibility. I would say the same thing even in a prison. You put somebody into a voc ed program who is going to be there 30 years, that voc ed might not even exist -- what they learned.

So I think it has to be the front end. It can't be the back end to go over, because that would be a complete waste of the treatment program. If the guy is adjudged okay in treatment and now he has to do another 15 years at Trenton Prison, it makes no sense. But the way you're suggesting, I think, would be good.

ASSEMBLYMAN MIKULAK: Okay. This Task Force, which was empaneled, had two meetings in the Avenel facility. We met with Mr. Plantier. I think one was in November and one was in December. Then we later found out that the therapeutic program that we were looking into was changed. The date of the December hearing that we had was, I think, December 6. Then I had some memos about the change that I later acquired -- December 7 and December 8 -- between Mr. Plantier and Mr. Hilton.

Do you think that does a service to the Legislature when we're looking into, we're focusing on, this type of program and you change it -- the Department of Corrections changes -- right before our eyes? It's like a magic act. We weren't there to hurt the Department of Corrections, but we were treated very hostilely.

COMMISSIONER FAUVER: Well, as I indicated in my opening remarks, I said that the Task Force should have been notified about that. But I think, as I tried to explain, this was something that was in process well before that. But that does not--

ASSEMBLYMAN MIKULAK: That is why I'm upset, because it was in the process and we were doing this at the same time. We were in the same facility.

COMMISSIONER FAUVER: Well, I don't know. Other than not being notified, I don't think there was any mandate for the Department not to go ahead, not to make changes.

ASSEMBLYMAN MIKULAK: No, but--

COMMISSIONER FAUVER: But you should have been notified, and I acknowledge that.

ASSEMBLYMAN MIKULAK: Okay. On page 46 of the February 1 meeting, I asked that question of Mr. Plantier and Mr. Plantier said, "Well, I can only answer what I know. I had no conversation with the Commissioner myself. If I was to guess, I would have assumed that he would have notified the Chairman of the Task Force. But since I had no dialog 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 had happened after that."

Who failed to notify us? Was it your responsibility?

COMMISSIONER FAUVER: Well, as Mr. Plantier said, yes, it was my responsibility. Yes, I think it was, I said that. I think there are two separate issues; notification is one. There should have been notification. Notification should have been given.

But the idea of this program being looked at, bringing in a national expert-- This is one of the suggestions that was made by her, to change the therapy groups. The other thing is it was talked about at least tangentially because there was discussion about doing it around the holiday season, because that was a slow time and it was a good time to make changes or to start to make changes.

If it came across as a slap at this Task Force, I apologize for that, but that was not the intent, and it was not

something that magically was pulled out of the hat at the 11th hour.

ASSEMBLYMAN MIKULAK: Sometime in January, myself and Senator Bassano were called by a reporter from the Associated Press and asked what we thought of this change. We couldn't respond. We didn't know about it. We are disappointed. It seems like a bureaucratic defense mechanism. Did you purposely--

You didn't think about notifying us? You didn't want to notify us? It just slipped your mind? Could you explain why you didn't?

COMMISSIONER FAUVER: Well, I think that it probably just slipped my mind. I didn't probably tie them together. But what I'm saying is, this was-- Somebody coming to me in December and saying, "Can we have final approval," to do something that had been recommended in a report back in July and discussed by the staff at Avenel, with some of our administrators -- Mr. Hilton and others-- I don't know what else to tell you.

ASSEMBLYMAN MIKULAK: Okay, thank you, Commissioner.

ASSEMBLYMAN HOLZAPFEL: Commissioner, just a couple of questions. It was always my understanding that once -- and maybe it has changed since I was a county prosecutor -- a finding of repetitive compulsive is made, I thought the judge was pretty much obligated to send somebody to Avenel. Isn't that the way it works?

COMMISSIONER FAUVER: I would say pretty much, but it's not 100 percent, I know that. I'm not sure what the percentages are.

ASSEMBLYMAN HOLZAPFEL: You have a handle on--

MR. PLANTIER: Percentages of people who are found repetitive compulsive, or that the judge--

ASSEMBLYMAN HOLZAPFEL: Right.

MR. PLANTIER: It's a very, very small percentage. I'd probably say it's less than 1 percent or 2 percent.

ASSEMBLYMAN HOLZAPFEL: Who don't go?

MR. PLANTIER: Who don't go, yes.

ASSEMBLYMAN HOLZAPFEL: So if you find that they are repetitive compulsive, about 98 percent of those people are going to come to you as inmates?

MR. PLANTIER: To the best of our knowledge, yes. It is a very small figure.

ASSEMBLYMAN HOLZAPFEL: Okay. Now, one of the questions that was asked before at one of the prior meetings -- and maybe the Commissioner has a better handle on this -- is there any information or do you have any sense as to what the recidivism rate is from someone who is a sex offender who goes to, say, Rahway or one of the other institutions, as compared to Avenel?

COMMISSIONER FAUVER: No, we don't. The recidivism rate of the person who goes to another prison would just be grouped in with the other people from that prison who are paroled.

ASSEMBLYMAN HOLZAPFEL: Okay, now back in-- Let me get the correct title of this. This is a Release Outcome 1984 Follow-up Study.

COMMISSIONER FAUVER: From Avenel?

ASSEMBLYMAN HOLZAPFEL: No, I assume this is for the entire system.

COMMISSIONER FAUVER: Okay.

ASSEMBLYMAN HOLZAPFEL: Yes, it is, dated February '92.

In there, on page 13, they talk about -- well, you talk about, or your people talk about -- Release Outcome Rate, 1984 release by most serious offense. We have sexual assaults under violent offense. Sexual assault we have listed there, and basically, the reincarceration rate is 17 percent. The

reconviction rate is 23 percent. So I assume that is an overall number including Avenel, as well as the regular sex offenders throughout the prison system, in this study?

COMMISSIONER FAUVER: I would believe that it is, but without having it--

ASSEMBLYMAN HOLZAPFEL: Okay. I guess the point I'm trying to get to is, that reflects, or your study reflects, out of total violent offenders the reincarceration rate, which is what I'm really interested in -- in other words, the people who are not only rearrested, but reconvicted and resentenced -- for violent offenders is 20 percent. So that would include people for robbery, assaults, murder, manslaughter, what have you, and that rate versus sex offenders or sexual assault is 17 percent.

So is it a fair conclusion on my part that of all violent crimes, on average 20 percent of them are reincarcerated, based on this thing, and if we look at sex offenders, again based on this study, the number is 17 percent? So there is only a 3 percent spread between your typical violent criminal who ends up going back versus someone who has either gone through Avenel or not? Is that a fair conclusion?

COMMISSIONER FAUVER: Yes, that is a fair conclusion, yes.

ASSEMBLYMAN HOLZAPFEL: As I understand it, you agree that long-time sentences, people who receive extensive sentences shouldn't go to Avenel? They should go to one of the other institutions and then at some point in time be transferred out to Avenel for the treatment?

COMMISSIONER FAUVER: Yes, I think that is one solution. I don't think we can continue to jam up the treatment staff at Avenel with the people who still have so many years to go.

ASSEMBLYMAN HOLZAPFEL: Okay, that's all I have. Thank you.

SENATOR BASSANO: Do we have other questions?

Assemblyman Malone.

ASSEMBLYMAN MALONE: Yes, I just have a couple of questions.

How many years have you been Commissioner of Corrections?

COMMISSIONER FAUVER: Since 1978.

ASSEMBLYMAN MALONE: Okay, 15 or 16 years. Are you happy with the structure of the Department of Corrections?

COMMISSIONER FAUVER: Well, I'm not sure what you mean by that.

ASSEMBLYMAN MALONE: Just answer just like I asked it: Are you happy with the structure of the Department of Corrections?

COMMISSIONER FAUVER: Well, I'm happy that I'm in charge of the structure of the Department of Corrections, I can tell you that. (laughter)

ASSEMBLYMAN MALONE: Are you happy with the structure of the Department of Corrections?

COMMISSIONER FAUVER: Well, I think things could be better, yes.

ASSEMBLYMAN MALONE: Okay. Now, I'm assuming since you have been in office 15 or 18 years-- If you were king, how would you set up the Department of Corrections?

COMMISSIONER FAUVER: Well, I don't know that I would set it up any differently than the kind of structure we have now, with the assistant commissioners down through the operating units, which are the institutions. We have the parole units. I think what I would be looking for would be more support in some of the areas, particularly spacewise, is one thing--

ASSEMBLYMAN MALONE: Let me be more specific. As to type of institutions you have, as to placement of prisoners in institutions, if you were king, how would you do it? If you said today, "Look, this is exactly the way I want it. This is

how I want it. This is where I want people." How would you do it?

COMMISSIONER FAUVER: Well, I'm not sure, because that kind of utopia never comes.

ASSEMBLYMAN MALONE: You've been there for 17 years now.

COMMISSIONER FAUVER: In the 17 years we've added, like, 15,000 bed spaces, so there are a lot of things that I would think we need that we got.

ASSEMBLYMAN MALONE: So in the time you've been here, you have never been asked as the Commissioner of the Department of Corrections to come up with a plan on how you would like to see the Department be structured and run, facilities, and where prisoners should be?

COMMISSIONER FAUVER: No, I didn't say that. I don't think-- We do that, in a sense, every year with capital budgets and with operational budgets. We have plans. We have two-year plans. We have five-year plans.

I think the overcrowding is the first and key issue that has to be resolved for us and for the counties; that continues to be the major issue. So I don't think it's anything in the sense of structure.

ASSEMBLYMAN MALONE: Just globally, you've never come up with the ideal plan that you would like to see as the Commissioner and say, "This is really the way I think that the whole Department of Corrections should be run. These are the facilities I think we need. This is where these types of prisoners should be." You've never been asked to do that, maybe?

COMMISSIONER FAUVER: Well, I think we have to some degree. But, for example, we're talking now about a new prison. We're doing more than talking; finally, something is happening with it at the prison in Bridgeton.

We have defined what we need there. We know that we need more substance abuse treatment programs, and we're committing a particular wing or a particular housing unit there -- housing units -- for that purpose. We're looking at whether we do that in-house, as far as run that, or whether we contract out to do the services. There are more people in the system with substance abuse problems than there are sex offenders, a lot more. I wouldn't say that we would focus entirely on sex offenders, because that wouldn't be true.

ASSEMBLYMAN MALONE: Maybe Avenel is only part of the problem? Maybe the whole system needs to give up that as far as how we are handling prisoners, where they're being sentenced?

COMMISSIONER FAUVER: I don't know what the criteria is that you're looking at.

ASSEMBLYMAN MALONE: Well, you're the expert, I'm not.

COMMISSIONER FAUVER: Well, the system is working. It's not ideal but--

ASSEMBLYMAN MALONE: I think that is debatable.

COMMISSIONER FAUVER: But that's the bottom line, I think. We're not in Federal court. We're not under any receiverships, masters, or things like that. We're one of only about 7 or 8 states where that is the case.

ASSEMBLYMAN MALONE: Are you happy with the operation at Avenel?

COMMISSIONER FAUVER: No, I'm not happy with the operation. I've talked to the administrator--

ASSEMBLYMAN MALONE: Now, that is something that has been in operation most of your tenure.

COMMISSIONER FAUVER: Yes.

ASSEMBLYMAN MALONE: What specific recommendations have you made to improve the situation at Avenel?

COMMISSIONER FAUVER: Well, I rely on them to come to me and ask for things, which they have done, for example, just

using the therapists as an example. But I have to weigh that against the other 24,000 inmates and what they need.

If you're asking me ideally, yes, we should have more money to be able to do these things. But my job is not just Avenel, that's his job -- Bill's job -- and not mine. It's to look out for the entire system and to try to make judgments that are equitable and fair within the structure that we exist in.

ASSEMBLYMAN MALONE: So Mr. Plantier has sent to you recommendations on how to revamp Avenel?

COMMISSIONER FAUVER: Well, he did on this one. He sent to me the thing that is in discussion, the change in the therapy.

ASSEMBLYMAN MALONE: Up until this crisis occurred, have you ever received anything from the administration at Avenel about restructuring Avenel?

COMMISSIONER FAUVER: Yes, I have. It mainly has been dealing with staff, or excuse me, dealing with therapists and what they need to be able to do outpatient, as well as the diagnostic and treatment programs.

ASSEMBLYMAN MALONE: Okay, but is that information available to us, so we can sort of look at the history of how this thing has--

COMMISSIONER FAUVER: Yes, I can get that for you.

ASSEMBLYMAN MALONE: Okay.

That's all I have for right now, Mr. Chairman.

SENATOR BASSANO: Assemblyman Zisa.

ASSEMBLYMAN ZISA: Thank you, Mr. Chairman.

I would like to address another issue that has come up during the course of these hearings. But before I do that, I would like to commend the Commissioner for coming here today and for addressing one of our concerns, and that concern was the fact that a new treatment program had been implemented during the course of these hearings and we were unaware of it.

The Commissioner has come here today. He has accepted full responsibility for that, even apologizing to the Task Force for that. I commend you for that because that is the truthful, forthright type of testimony that we have hoped for throughout the course of these hearings. The reason I say that is because that hasn't always been the case.

At our last hearing, Mr. Plantier and certain members of administration testified before us, and also some employees of the facility testified before us. What happened during the course of that testimony was that certain statements were made concerning the truthfulness of the testimony by the various parties.

I want to read -- so that you are aware of it -- some statements that were made, and to get your read on what you think of it. A staff member, who is not identified in the transcript, made a statement that states, "I also want to say to the Commission that some of what you've heard today is inaccurate" -- and I'll interject that he was referring at that point to comments made by the administration officials -- "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."

Later on, to follow it up, I specifically asked two of the employees a question. That question was, "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. Craig Conway answered, "Absolutely so." I then asked, "Do you feel the same way, Ms. Jackson?" referring to Dr. Kay Jackson, who replied, "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."

Now, the reason I bring that up, and I want to be very clear on this, is not that I am in any way suggesting that the administration lied to this Task Force, nor am I suggesting that the allegations made by the staff members were untrue; however, it is obvious that somebody was not truthful with the Task Force, either the administration officials or the staff.

Now, the members of this Task Force, who are legislators and who are citizens, have given up a great deal of time at their own personal expense to be here in an effort to make this facility the best that it can be for the State of New Jersey. We don't take that lightly. We would expect that anybody who is here on behalf of the State or that facility would come here, just as you did today, and be forthright and truthful in their testimony.

I really want to get a sense from you on what you think needs to be done as a result of that. It's a separate issue from where we're going, and I apologize for taking the time out here, but that is an issue that needs to be addressed. I would like to know if you feel it needs to be addressed, and how you would address it?

COMMISSIONER FAUVER: Well, I'd have to know, I guess, first the topic where they say what was presented was not true, then I could give you a judgment on that. But I know that-- I'm not sure of the date on the report, but I know that both of those people are still employed.

Another thing that comes up with this -- this is digressing a little and I apologize. There are not people clamoring to go work in prisons as psychologists, as therapists, as anything else. It takes a special person to do that. I think the staff at Avenel really deserves credit for hanging in there with some bad situations.

As I said earlier, people disagree. If they disagree on what the program is-- If Dr. Jackson, whoever, decides that she thinks it should be something different, that's fine. But,

you know, a judgment is made. Just like in here, there will be divergence of views. You'll hear from other witnesses. You'll hear from experts from other states who are going to tell you, "This is how we do and this is what we think will work." I don't think there is a right or wrong until we get the results, then maybe we'll know.

But I don't know what the topic was that they're saying was not true. If you want me to look at it, I'll be glad to and get back to you.

ASSEMBLYMAN ZISA: Well, I'm not sure that the topic is as important as what happened. The topic happened to be the treatment program.

Let me try to clarify where I'm going with this. What I'm saying is that the administration appeared here. We depend on them to run the facility; we depend on them to report to us what is going on. I have no reason to believe that they weren't truthful.

We then have employees, who possibly are disgruntled employees, who might be inclined to misrepresent the facts. If that is the case, then I would expect action to be taken. If, on the other hand, they are not disgruntled employees, if, on the other hand, they are persons who are very concerned and felt that it was necessary to appear here, in their perception at the risk of their jobs -- whether that's a fact or not -- and to be truthful in exposing that the administration purposely misrepresented the facts, that would be a serious problem. Either way, we have a serious problem.

I don't think the topic matters as much as the fact that allegations were made before this Task Force that somebody purposely lied to us. What I would like to see is -- I'll suggest this and if I'm out of line, the Chairman can tell me -- an investigation conducted by you or your designee to determine who didn't tell the truth before this Task Force.

You will have this available to you. You can look up the subject matter. I would like to see you conduct an investigation. I would like you to take the appropriate action based on the fact that someone, who is employed by the State of New Jersey, appeared before a legislative task force and purposely misrepresented the facts, if that happened. It had to happen because there are two different versions.

This is not a question of who thinks the treatment program is better. This is a question of a statement being made that facts were purposely misrepresented and that people purposely were untruthful to the Task Force, not which was a better treatment program. That is not the point.

So what I am asking is for you to investigate it, as I say, as a separate issue, to get back to us with some type of report -- some type of communication -- which would indicate to us what you have learned and what action you plan to take on it. That is what I am asking.

ASSEMBLYMAN MIKULAK: What page were you reading from, Charley?

ASSEMBLYMAN ZISA: The first statement was on page 151. That was the staff member who said that "some of the things I just heard stated as facts, aren't." Then on page 156 -- because I wanted to be clear -- Craig Conway and Dr. Kay Jackson very emphatically stated that the administration purposely misrepresented the fact and were untruthful to the Task Force.

Now, I am not suggesting that is the case. I am saying that is what they alleged.

COMMISSIONER FAUVER: I know. We can interview people and--

ASSEMBLYMAN ZISA: It's a coin toss.

ASSEMBLYMAN MIKULAK: I think that is a fair request. You'll comply with that?

COMMISSIONER FAUVER: Yes. But I find it hard to believe that Bill Plantier would not be honest on-- He was honest in saying it was the Commissioner's responsibility to do something, and he's still here. He didn't get fired. (laughter)

ASSEMBLYMAN MIKULAK: I found it hard to believe that Bill Plantier didn't tell us when he was changing the therapy, Commissioner, so--

ASSEMBLYMAN ZISA: I am not suggesting that.

COMMISSIONER FAUVER: No, I know you're not, I'm only teasing.

ASSEMBLYMAN ZISA: I am not suggesting that at all. I am saying that if, in fact, it is a case of disgruntled employees trying to bring down their administration, I want to know about that.

COMMISSIONER FAUVER: Yes, that should be dealt with also.

ASSEMBLYMAN ZISA: That has to be dealt with, because somebody who would purposely malign the reputation of a State facility is a serious problem for the State. So, whichever the case, I would hope--

COMMISSIONER FAUVER: Which report is this, Assemblyman? Is this the last one?

ASSEMBLYMAN ZISA: This is the transcript of the February 1, 1995 meeting.

SENATOR BASSANO: I think what the Assemblyman is saying is that when we're not told the truth our job becomes that much more difficult. So we would like you to take a look at that issue and maybe get back to us through our staff person, Anne Stefane.

COMMISSIONER FAUVER: I will.

ASSEMBLYMAN ZISA: Thank you very much.

ASSEMBLYMAN MIKULAK: Senator Girgenti.

SENATOR GIRGENTI: Thank you very much.

Commissioner, just a couple of questions. I want to get clarification on some of the things you said, and also some input.

Number one: During our discussions through the various meetings we've had one thing that has been discussed and talked about, the possibility of maybe not having Avenel as it presently exists and putting people back into the system the way it was in the past, in the different prisons -- having that kind of a situation.

Is that an option that you have thought of, or do you think the direction is to continue Avenel as it presently exists and not move back? What purpose is served by moving them back into the prison system? Have you ever thought of that?

COMMISSIONER FAUVER: I think the Avenel concept is still the way to go. I think that moving them back into the system would not be. There is always -- not always -- there is a debate in other states and there has been here: where should this even be? Should it be in Corrections? Should it be in a Human Services type of setting?

It was under Mental Health and Hospitals in the '70s before it was changed over to Corrections. One of the reasons was escapes from hospitals and things like that -- not major reasons. I think the thinking at the time was, as I said, tied into this therapeutic community idea of all likes being together, living together, not being able to get over on each other in therapy, and stuff like that.

I think, as I said earlier, we can't exclusively do that though. I think you have to sort out the long-term guys. They go to regular prison first and then come at the end. I think we also have an obligation then to provide some kind of treatment, even if it's just a preliminary type of thing, at those institutions.

SENATOR GIRGENTI: Well, we've heard from different people that a couple of states have tried to work with setting

up a unit similar to Avenel and it hasn't really-- I think California has closed down what they've attempted, and I believe another state has also attempted it. Virginia? I'm not sure which state it was.

ASSEMBLYMAN MIKULAK: California and Virginia.

SENATOR GIRGENTI: The end result was that they decided the experiment did not work, and they went back to the system the way it was before.

I only brought that question out because there are a couple of things-- One thing that we have heard throughout our meetings has been that there are a group of people who are treatment refusers. It is a group of anywhere -- I have heard percentages from 10 percent up to 30 percent. What is your feeling with these types of individuals?

I know you said there should be a certain amount of time. I know Mr. Plantier also said that he would hate to have a situation where we put somebody back into State prison, and it turned around and they said that somewhere along the line he could have possibly wanted to have help, at some point years down the line. But one of the feelings I have is that it is a slot there that could be used for somebody that may be able to get that help.

How long do we spend with this type of individual? Do we say a time limit of a year, six months? If the person is a treatment refuser, then I figure they're taking up somebody else's slot, in my opinion, and they should go back to prison. I know the problem has been that sometimes it was better, some people wanted to go back to State prison because they could get out earlier.

What do you suggest in that area? Do you think--

COMMISSIONER FAUVER: I think if you're there-- I mean, I'm not sure what I would say as far as the time frame goes. I think that I would be of the belief that one of the

missions from Avenel is to try to get people involved. But you're not going to succeed with all of them.

I think if the person goes back into the regular population, clearly they should never be able to get out sooner than somebody who stays, is in the treatment program, and is successful in the treatment program. So I think that has to be more, in a sense, codified so that won't happen. One of the ways to do that, as Senator Bassano said earlier on, was to continue them on some kind of supervision even after they get out, whatever that might be.

I'm not sure what the time line is on that, John, as far as "when," but I think that is something that should be looked at, yes.

SENATOR GIRGENTI: Okay. Because you're finding that there is a certain percentage that are noncooperative?

COMMISSIONER FAUVER: Yes.

SENATOR GIRGENTI: At what point do you say, "Let's use this slot for somebody who can have some successful results?"

COMMISSIONER FAUVER: But, you know, you come in-- Whatever the malady is, in a sense, whether it is substance abuse or this, there is a period of denial by the person in there and there has to be some time to get past that.

I've worked with groups in the past, with young people who were murderers, and they were extremely difficult in the beginning to get to do anything.

SENATOR GIRGENTI: One suggestion that we had brought out -- I think it was Senator Bassano earlier in the meeting -- was that maybe we could have some kind of a situation set up where somebody puts time in State prison and then has to go through some type of therapy through Avenel, before they are allowed back out into society, like a dual system. Has that ever been thought about from the perspective of the Department of Corrections? Is that a viable answer to a problem?

COMMISSIONER FAUVER: It has been thought about. I think it is a possible answer to the problem. We've done that to some degree in the counties where we have had sex offenders backed up, and we have had to provide some, at least, fringe part of treatment to them while they are there. Yes, I think that is something that could be looked at.

SENATOR GIRGENTI: Okay, just ending up, a couple of things. I understand what you're saying. One thing that did come up, and I happen to agree, is that you have certain people in Avenel who are elderly -- and at some point I think you were in agreement with it -- and we should move them out of there. Because, again, that is a slot that is taken up. If a man is at the age where he is up in his 60s, 70s, and so forth, I don't know how he can continue to want to have therapy and so forth. Again, that slot is a slot that somebody else could use. I guess you're in agreement with that, that they should be in that type of position?

COMMISSIONER: Yes, pretty much. I think a problem in the whole system is the aging of the population, the geriatric care.

SENATOR GIRGENTI: All right. The other thing is I don't remember your answer, if you did say-- Do you feel that indeterminate sentencing in this case -- going back to the old system in this kind of category -- would be, in your opinion, effective as opposed to what we presently have, if there was, obviously, a longer duration?

COMMISSIONER FAUVER: I didn't answer that, so you didn't miss the response. (laughter) I'm not sure--

SENATOR GIRGENTI: I know we have a problem with the overcrowding, on one hand.

COMMISSIONER FAUVER: Yes. As you are aware, initially the sex offender sentences were indeterminate sentences with a max. I don't know. I'm not sure I have very strong feelings about it either way. But one of the reasons it

was changed was the subjectiveness in the decision making. I guess maybe it was felt that the courts could do it better, I'm not sure, than the staff at the institution.

SENATOR GIRGENTI: One last question: Is there talk of setting some kind of formal aftercare type of program into this process? I know we do have aftercare, but it is more or less on a voluntary basis. I think one of the things that was brought out, and I feel is important, is some kind of network be set up so that part of the parole should be that they have to be in aftercare.

As you know, we were involved in this package of bills, and one thing I felt very strongly about was lifetime supervision. I think we have to continue to have accountability. We have to know everything these people are doing so people don't fall between the cracks, as has happened in some of the cases in the past where somebody leaves the State, we lose track of them, they come back, and commit another offense.

What we need is that absolute situation where they have accountability. I think that the way we should head is, a condition of parole has to be-- They have to continue to have counseling and so forth, once they're released. We need an aftercare element to be incorporated. I don't know what the budget says in terms of that, but I think that is something that we really have to seriously address. It can't be a voluntary situation because we've heard ourselves-- What is the percentage? Maybe two out of thirty might go to it, two out of fifty.

COMMISSIONER FAUVER: Yes, well, there would be no pressure on them to do it otherwise.

SENATOR GIRGENTI: I want to thank you for your information. We've always been willing to work with you, and you know we will continue to.

COMMISSIONER FAUVER: Thank you, Senator.

SENATOR BASSANO: I think if we start paroling people instead of letting them max out, we can establish that type of program and make that a requirement. I think the success ratio would obviously increase if we did that.

There are two other Senators who want to speak.

Senator Inverso had a question.

SENATOR INVERSO: Yes.

Commissioner, I recall the first hearing, and I had asked the question: What is it that Avenel needs to do a better job with regard to the Task Force? I did get back some information -- I guess the full Task Force received it -- with regard to dollars to add therapists to improve the ratio and, hopefully, improve the number of contact hours that the therapists have with the prisoners there. But that was about it with regard to my request.

I'd like to challenge you now to provide to this Task Force, in view of the hearings that we've had, in view of the obvious shortcomings that do exist -- and that is not meant to be pejorative in a critical sense, but there are shortcomings -- which have been imposed upon you by funding constraints, some of which are, in my view, program shortcomings.

I want to challenge your department to come back to this Task Force with what kind of modality, what kind of changes you would like to see implemented, that you would like to see this Task Force consider and make part of its final recommendation, and if need be, certainly, legislative changes.

We're all hitting on kind of the same valves here with regard to what has been the situation at Avenel, what needs to be aftercare, ongoing supervision, all of those we've touched on. Now, we need to pull it together. We've got the individual pieces of the puzzle, let's pull it together.

We're going in one direction. You've heard comments by the Chairpeople as to some of the things this Task Force will

be pursuing and ultimately recommending. It would help me certainly, and I would like to know for direction, what you see as the changes that are important for you to pursue your mission more appropriately, and to also protect the community with regard to individuals who leave Avenel or leave the general prison population if they haven't been committed to Avenel?

We've got to work on this together comprehensively. Some of the things may be outside of Corrections' purview once they are released from your control and supervision, but we need to know. We know what the problem points are. We need to know what we have to do to help you. I think together, between your recommendations -- your litany of things -- and what we have so far heard and evaluated in terms of potential changes, maybe we can pull something together that makes a lot of sense.

I don't like to see this, and I don't think this Task Force cares to go in a direction where there is kind of an antagonistic, polarization approach to our recommendations. They may not be things that you are comfortable with. That may not matter, but we need to know what you think ought to be done so that together we can kind of gel something.

Obviously, you said you wouldn't abandon the concept of Avenel; that's fine. Obviously, an hour and a half of therapy contact is not appropriate; fine, that takes resources. But it also takes some other changes in regard to getting inmates motivated to have the therapy. I understand, and I heard at the last hearing that in some respect Megan's Law has worked as a positive in that regard; that the inmates are a little more interested. They are a little more open to therapy. That is great, but we need more than that to make them participate in the program.

I'm concerned about the recidivism numbers, 17 percent for the sex offenders versus 24 percent for overall general prison population. I just don't know if those numbers are correct. I have some reservations about those numbers. If they

are correct, fine. That means then we can probably do better in lowering those numbers if we have ongoing therapy, ongoing monitoring, ongoing supervision, because, obviously, there is a lack of that there.

That 17 percent is not a bad recidivism rate. I would like to see it down to zero, but it is not an ideal world we live in. But if that is the recidivism rate in view of the shortcomings to the kind of systems that we have in place here in New Jersey and elsewhere through the country, I think that is remarkable. That is why I think I have some skepticism about those numbers. We need to get those numbers updated. That is another issue that this Task Force, obviously, will undertake.

But to summarize, I need to have you come back to us and say, "Gentlemen, ladies, in view of everything that has gone on and the hearings that you've held, these are the kinds of recommendations we would like to have you consider." Then we'll take it from there.

Mr. Chairman, I hope I'm not out of order in that, but I think it would be good.

SENATOR BASSANO: I think Peter's suggestion is excellent. We are discussing up here, among other things, when we are going to meet again to try to finalize a report. Maybe one of the things that you can do, working through staff, is come up with some ideas that you may have that you would like to see us incorporate, so we can discuss those ideas the next time this Task Force meets.

COMMISSIONER FAUVER: I would be glad to. This kind of ties in with, I think, what Assemblyman Malone was asking -- if I had the best of all worlds all over. But maybe we'll just give you what we think the best of all worlds is at Avenel and for sex offenders.

SENATOR BASSANO: That is fine.

Peter, did you want to continue?

SENATOR INVERSO: No, thank you.

SENATOR BASSANO: Senator Matheussen, you were next.

SENATOR MATHEUSSEN: Yes, picking up actually where the Assemblyman started and where Senator Inverso left off, that is essentially what I was going to ask about.

Commissioner, I know that a number of your staff are here with you today. I hope somebody has been making some notes. Because I, quite frankly, think the way the legislative process works with regard to this issue-- So far, you have been asked to come -- the Department has been asked to come -- to be a participant I guess in a way and just give us information.

I think it would be a shortfall for this Task Force not to have you participate in a very real sense in giving us an outline and giving us a wish list of what it is that the Department of Corrections thinks its needs are to improving what we have right now.

I do hope you've made some notes, because Senator Inverso, I think, gave you a number of things that we hope you would touch on. I would add a few more.

There are things that we've been talking about over the last couple of meetings: Address the Penal Code, the fact of being repetitive. Do we need to change the Penal Code so that a judge is not necessarily having his hands tied to determine whether or not a person has been repetitive compulsive? What about that first-time offender? Do we need to treat them? Do we need to change the Penal Code so that we can treat them at Avenel?

Senator Girgenti has brought up, and did discuss -- because I was at the hearings concerning Megan's Law and he was a proponent of it -- basically the aftermonitoring. I would rather not call it aftercare, but aftermonitoring of those who are released. How can we do a better job of doing that and making sure that the people who are on the street are keeping in contact with the system, so to speak?

Geriatric care: There has been some criticism over the last couple of days. We've heard it again about "three strikes you're in," and how much extra burden and expense this is going to bring on the system. I'm concerned about that, but I'm also very concerned that these people are being released.

But, I also recognize the fact that if, in fact, we have geriatric prisoners, then there is probably a cheaper way to house them and incarcerate them until the expiration of their term -- whether it is the expiration of their life or the expiration of their term -- than it is for someone where we need maximum security. If they're, in fact, geriatrics, we can probably do it a whole lot cheaper. I think that is one way we can hold down the costs of three strikes and you're in.

Improvements at the correction institutions: What improvements do we need to make, but I guess, particularly, at Avenel? What can we do to improve those systems? One that I was most shocked about and we talked about over and over again was not the fiscal planned improvements, but the actual idle time that we saw.

I don't necessarily think that people at Avenel -- the inmates at Avenel -- should be doing community service, out in the community doing something, but I think they should be doing something. I don't think it's good for anybody, whether they're a prisoner or they're my 13-year-old son, to sit around for a long time doing nothing. I think, quite frankly, it is something we really need to look at. We've got to find something for those inmates to do. I don't care if it's busy work. Whatever it is, they've got to be doing something, and I don't think it's community service.

But those are, I hope, the things that you will get back to us on, because without your input I don't think this Task Force can really finalize its mission. You have to be involved in this. Your department has to be involved in this because you are the experts in this area. We need to hear from

you so we can finalize and, hopefully, have some meaningful conclusion to what we've been doing for the last couple of months.

Thank you for your participation up to now, and I ask you, through the Chairs, to continue to participate in a real sense so that we know what it is that you need.

COMMISSIONER FAUVER: Thank you. Okay, I'll be glad to, Senator.

ASSEMBLYMAN MIKULAK: Assemblywoman Turner.

ASSEMBLYWOMAN TURNER: Thank you, Mr. Chairman.

Thank you, Commissioner, for being here with us today. I have several concerns.

One regards the last time we met, when we learned that all inmates at Avenel are not required to participate in the therapy in order to get the benefit of good behavior credits. That was a great surprise to me and also a real concern. But I was also told that as a result of the bill that was passed as part of the Megan's Law package, it did not make that law retroactive to apply to all inmates.

COMMISSIONER FAUVER: That is correct. That is our understanding of it.

ASSEMBLYWOMAN TURNER: I was also told that the Department would be most appreciative if that law applied to all inmates. Is that true? You would like to see--

COMMISSIONER FAUVER: I would like to see it, yes. I won't speak for Bill.

MR. PLANTIER: Yes, certainly.

ASSEMBLYWOMAN TURNER: As a result of that, I did introduce legislation to make that retroactive so that no inmate at Avenel, no matter when they were admitted, would be able to have those good behavior credits without the treatment.

COMMISSIONER FAUVER: That is great. Yes, we'd certainly support that.

ASSEMBLYWOMAN TURNER: The other area of concern regards-- You indicated earlier, at the outset, that you have problems with providing statistical background as far as recidivism. You don't have the resources to provide the type of statistics that would be more accurate in determining recidivism. Is that what I understood?

COMMISSIONER FAUVER: Yes, but I think that is improving. We're getting pretty much computerized now. It is going to be easier to do. What I said in response to the people who went through, and I know what Loretta was responding to when she said earlier -- not today, but at other hearings -- that we really have to do that almost on a case-by-case basis. You know, start with inmate A and just keep going down to see where they are at a given point.

I don't think we're too far away from being all computerized and us being able to do that. But, again, as I said, one of the things -- and I think this is part of Senator Inverso's question -- is the definition itself. Is it arrest and reincarceration? Is it just arrest? Is it an arrest for stealing a car when before the person was an armed robber or a sex offender? I mean, there are answers to those. I just threw that out.

But I think that within-- I'm not sure, I don't want to give you a time frame because I'm so used to dealing with construction projects that time frames become meaningless. I think in the near future, really, we should be able to do that computerwise. Then it will be more easily accessible and also accurate.

ASSEMBLYWOMAN TURNER: I think right now it is patently clear that we have to be more accountable in terms of the dollars that we're spending. Our taxpayers are demanding it. I think this administration, too, is demanding that we get the biggest bang for our buck. So if we can show how that money

is being spent and the benefit that we are deriving from it, I think it will be easier to get budget requests fulfilled.

But I wanted to speak to the legislation that was just passed this week by the Assembly, the "three strikes and you're in." I think that is nothing more than a bumper sticker slogan, and my concern is this: What is the philosophy of our penal system? Is it one of warehousing or is it one of rehabilitation?

I think with this three strikes and you're in it is going to place, certainly, more financial pressure, as well as other types of strains and burdens, on an already overburdened and crowded system. But if we're going to be saying that these criminals are going to have one strike, two strikes, and then three strikes, is it going to be the policy of the prison system to try not to have them come back for that second strike and third strike? Are we going to rehabilitate them? Are we going to provide them in some way with job skills or educational training, drug treatment, so you will not have them for the rest of their lives? They will not go out and come back and have to serve a lifetime sentence.

Also, the question, too, of prison reform: It is my opinion -- I have no data to back it up-- I don't think that criminals really fear imprisonment, because they have all the luxuries in prison that they have at home and sometimes more. They can bring their TVs, their stereos, their CDs, their computers, and they get three hots and a cot.

They don't have to pay anything for medical services, which we do in the private sector. Many working people can't have free health care or dental services. The only thing that they suffer is some restrainment. They can't come and go as they please. They get paid for sitting around doing nothing all day, and they can use that money to go to the commissary to buy whatever personal needs they want.

So what is the deterrent there? I don't really see the three strikes, saying you're going to be locked up for life, as a real deterrent to crime.

COMMISSIONER FAUVER: Well, I think what the place is like is, in some ways, irrelevant. If it is nice or if it is terrible, the fact that at 10:00 at night the door slams shut, you're locked in, somebody else lets you out at 6:00 or 7:00 in the morning, and you have no control over your own destiny in that sense.

I think it's easy to say that may not be enough. I'm not sure, but I think it would be enough for me, I'll tell you that. If that were the situation that was happening to me every day for the next X number of years. This room is a nice room, but you wouldn't want to stay in here for an elongated period of time.

I think one of the things that you addressed, and some others have too, would be the aging of the population. I think that is one of the things that we don't have now. We don't have the geriatric center or a place to put people where then you would free up the bed space for others in the less desirable institutions, if you will.

But I think we are still going to try to provide the tools for a person to help themselves, whether it's education, voc ed, drug treatment, drug and alcohol treatment. Substance abuse among the population is still the most prevalent issue. More people in have a history of abuse than any other offense.

Those things we are-- As I indicated earlier, with the Bridgeton Prison, we're trying to -- not trying, we're committing a certain portion of that prison to substance abuse counseling. So we're going to continue to try to do that. What happens is you get overwhelmed with the numbers, and that is the situation we're in right now.

I hope that addresses at least some of the--

ASSEMBLYWOMAN TURNER: But do you feel that your job is to warehouse or do you feel any--

COMMISSIONER FAUVER: No, I don't think that at all. I think my job is to provide a secure, safe system, to try to provide programs that will help people to make it on the street, and at the same time, to protect them from each other, protect our staff, and protect the public. I don't think those are necessarily divergent issues. I think they all mesh. So I don't think we're just warehousing at all.

ASSEMBLYWOMAN TURNER: Do you feel that your recidivism rate is satisfactory? Is it respectable?

COMMISSIONER FAUVER: Well, I don't know. I think the issue isn't really what is it -- which I'm not sure what it is, I've heard the figures today. If we're talking about 20 percent or 20-some percent of people who have not made it before but are making it now, that's good. But I'm not sure that group is all making it. We just may not know about it. That is another group in the middle. It is somewhere in between.

ASSEMBLYWOMAN TURNER: Apparently, the overwhelming feeling is that the majority is not making it; otherwise, we wouldn't have this three strikes and you're in legislation that is pending the Governor's signature right now.

COMMISSIONER FAUVER: As I've said, I think it is unrealistic for the public or anybody else to assume that the corrections system, the prison system, is going to turn people around that all the other institutions of society have not been able to, whether it's school, church, family, whatever. All we can do is give our best shot at it.

SENATOR BASSANO: May I just interrupt? We're kind of drifting from Avenel into the general problem of prisons. So if you could stay more to Avenel--

ASSEMBLYWOMAN TURNER: Okay. Well, thank you, I'm finished.

ASSEMBLYMAN MIKULAK: Mr. Thomas.

MR. THOMAS: Most of the questions that I had have been answered. We've all talked a lot. We've all asked--

I would like to make a statement. I was going to make this statement later on, but I think the time is now. Before I make this statement, I want to stress one thing. I am not talking about individuals. I'm not pointing at individuals. I'm talking about the system, and that is this side of the table with the other side of the table. I'd like to start now.

Just prior to the closing of the last two Task Force meetings, I made a statement. A copy of both statements and references are available.

At this time, after additional thought and research, I would like to summarize the results of my findings, as a nonprofessional, and offer the following summary:

1. New Jersey is one of the few, if not the only state, offering a separate prison facility for the evaluation and treatment of sex offenders. Other states do offer treatment but in a regular facility.

2. I've talked with the states of Virginia and California, and they recently completed lengthy studies regarding the treatment of sex offenders. They are now discontinuing their special programs as of June of 1995. The programs were found to be noneffective and costly.

3. Of all the psychologists specializing in this type of offender or treatment that I have contacted, and I have contacted them all over the United States, not one suggests a cure for a pedophile. I'm not talking about a rapist. I'm talking about a pedophile. They state that only a small percentage, if any, can be helped.

Recent studies now show that lifetime parole and constant monitoring are required. We cannot continue releasing maxed out prisoners into our community. A nationally known psychologist -- he is one of the top in the country -- has stated to me that without follow-up, New Jersey has wasted

treatment, time, and its money. We have also endangered our public and our innocent children.

4. We have been unable to determine the effectiveness of New Jersey's program, as proper records have not been kept and no evaluation report has been made over the last five years.

When I start on this I'm still talking about the system: Our administrators of the Avenel facility have not been prepared to help this Task Force in the evaluation or the investigation of the effectiveness of this program. They have stated that they are not responsible for the attitude or the type of prisoner because the prisoners are assigned to Avenel by the courts.

Their treatment and therapy is limited by the insufficient funds provided by the legislators. They cannot evaluate the effectiveness of their program or keep proper records because of the limited funds provided by Trenton. They also do not control the readiness, the time of release, or the responsibility for release because the prisoners are maxed out by law.

Our State undertook this program approximately 20 years ago. At the present time, our annual cost is in excess of $25 million to house approximately 725 offenders, where we offer at most four hours of group therapy a week -- four hours -- most of them get an hour and a half or two hours. Thirty percent of the 700 don't want any. They do not accept it. They do not receive it. Another 30 percent, as we all know, go through the motions and have little interest. If you don't have any interest, you don't receive any help no matter what your problem is. So they receive very little help.

So, at best, we have provided in this State a full facility to provide only limited treatment to 300 that participate as sex offenders. We don't keep any records or make any study as to where we're going and what the effectiveness has been.

It is felt that it is about time that we should consider directing our tax dollars to programs where we have a better potential of better results.

In conclusion, I believe that we must change our sentencing practices. Sex offenders should be sentenced to serve their time in regular State prison. Therapy should be treated as a privilege that must be requested and warranted, and then we, where it is wanted and requested, furnish better treatment in a regular prison facility.

We have asked our Avenel administrators if they would be comfortable with treated offenders released in their neighborhoods, and their answer, naturally, was in the negative. How can we continue to maintain this facility and release so-called treated sex offenders unmonitored?

We have given this program more than ample time and it has not proven to be successful. It is time to close Avenel as a diagnostic treatment center and put it to other uses within our correctional system, where we will have a better potential for more rewarding results.

I think it is the duty of this Task Force to bring about change at this time and no longer can we support the status quo.

I thank you. Now, if you have any questions that you would like to ask me about my statement, or if you would like to ask any question of a victim, who is a grandfather, a father, a husband, I will be glad to reply to your questions. (no response)

I thank you for your time.

ASSEMBLYMAN MIKULAK: Thank you, Mr. Thomas.

SENATOR BASSANO: Professor Brooks.

DR. BROOKS: I would like, if I may, to direct some questions to Commissioner Fauver based on your statement. Is that agreeable to you?

MR. THOMAS: Yes, it is. After that, Gregg Muller would like to speak.

DR. BROOKS: Commissioner, Senator Girgenti asked you a question about the possibility of eliminating Avenel and substituting treatment in various regular prisons as an alternative, and that has also just been raised.

You responded with what a lawyer would call a conclusory answer. Namely, you said you didn't think that was the way to go; conclusion. No reason given, no analysis, and many of your responses, if I may say so, have been very conclusory here, and the Senators and Assemblymen have accepted those conclusions. They have not penetrated beyond those conclusions. They ask you, "Commissioner, what do you think?" You say, "This is what I think," next question.

May I respectfully ask you at the beginning: What is your response to the question that has just been raised in this statement, and that the Senator also raised?

Before you give that response, may I indicate to you that there is a general feeling among many members of this Task Force at this time that the treatment that has been given for many years at Avenel is useless. Now, this view that it is useless is based on at least two factors.

One, there is an enormous body of research indicating that, at best, the kind of treatment given at Avenel is useless. But even in those situations where there is an effort to say there has been some success, has been with programs in which much more therapy has been provided than at Avenel.

I think, quite frankly, if I may say this, that for a large proportion of inmates at Avenel to get one, two, three, four hours a week of therapy is a farce. Because even if it were successful elsewhere, it certainly has no chance of being successful here.

Furthermore, I think it is fair to say that this Task Force and the New Jersey Legislature is not about to increase

substantially the amount of funding for therapy that would make it reasonably efficacious.

Now, if that is true, even if you add a therapist here or there, it is foolish to suggest that is going to make any significant change where you have 700 residents of an institution like Avenel. I mean, let's be realistic. These changes that have been made -- which, of course, this Task Force wasn't even told about -- are trivial. They're trivial because you monkey around with a few changes here and there, it accomplishes nothing.

Now, I would like to ask you, Commissioner, what is your response -- and this is only my first question -- to the proposal given in addition that so many inmates at Avenel refuse treatment, go through the motions of treatment, and get no help from treatment, to have a new approach in which the treatment function of Avenel is terminated and treatment is made available in the various prisons of the State only to those sex offenders who initiate requests for treatment, and where they get no benefit other than the treatment itself from having requested treatment -- no special treatment?

SENATOR BASSANO: Professor, do you have a specific question of the Commissioner?

DR. BROOKS: Yes, I do.

SENATOR BASSANO: Okay. Please ask the specific question.

DR. BROOKS: I did, but I wanted to indicate where I was coming from, Senator, so that he would be able to focus on the point that I am making, which is: How do you respond to that approach? Here is a major approach that is being presented. What is your response, other than to say, "I don't like it," or, "Maybe"?

COMMISSIONER FAUVER: Well, I think that I have answered. I didn't come--

DR. BROOKS: You have not.

COMMISSIONER FAUVER: Well, that's your opinion, but I think I have. I think if a Senator or Assemblyperson or any member wants to follow up on what was asked, that is their prerogative to do so. I wouldn't write off the fact that they would not come up with more money to do programs, which you seem willing to do.

I think when I'm asked something it is because of my position not because of me personally. I think that is how I've tried to respond. I don't know what analytical judgment has to go into why I respond a certain way. I answer the questions to the best of my ability. I was asked a question, "What did I think was better," and I said, "I'm not ready to write off the Avenel model." It may be written off; this body, the Legislature, other people may do that.

But I think if the theory that is still in vogue with drug and alcohol treatment is to put people together in whatever kind of community, for want of a better word -- a therapeutic community -- why not do the same thing with sex offenders? What is different with it? Obviously, I know there are differences, but I would just say that I would stand on what I said, not to embellish it.

DR. BROOKS: So if I may paraphrase what you said, the analysis that you have given us or the reasons for wanting to stay with Avenel as it is, is the concept of a community where you have 700 sex offenders in one place, and you think that is not only a good idea, but that justifies having an institution like Avenel?

SENATOR BASSANO: I don't think that is what is being said. I think what the Commissioner is saying is that therapy can be effective, but some of the problems he has we created as a Legislature, and I think we have to try--

DR. BROOKS: How did you as a Legislature create--

SENATOR BASSANO: I think that the changing of the Penal Code in 1978 is the most glaring change. I can tell you

I was here, and I voted against it, by the way. But changing the Penal Code where we did away with the mandatory 30-year sentence, I think, was one of the major mistakes that we made. Plus the fact that the Legislature, in my opinion, didn't provide additional backup help for these people once they were paroled. Plus we didn't give parole to these people. We're letting these people max out now under the old Penal Code.

I think if we start making some of those changes, we'll start seeing a better success ratio. If we look at what Mr. Plantier told us earlier, Superintendent Plantier said if we can try to maintain that 30 to 1 ratio that has to help. If we start taking people out of that institution who don't belong there and putting them back into the general prison population, that has to help.

But I think that therapy is successful to some extent, but we have to start maybe being a little bit more careful as to who is going to be in it and how we're going to let people back onto the street.

ASSEMBLYMAN MIKULAK: I don't think, Professor Brooks, that we are taking the Commissioner at face value. I think I expressed my disenchantment with the Department of Corrections this morning. I think there was a point in the life of this Task Force where we were looking at therapy, and then we became unable to look at the therapy because they changed the therapy in the middle of the game.

So now we're moving on to some things that we can do which are, I think, going to be significant, like increasing the sentence time and decreasing the population at Avenel. So I don't think you're going to see-- The end result of this should not be a 700 member facility with 700 sex offenders.

DR. BROOKS: I understand, Assemblyman, but if I may pursue this for one moment?

ASSEMBLYMAN MIKULAK: Sure.

DR. BROOKS: It seems to me that since we're in the process of exploration of alternatives, the alternative of terminating Avenel -- which may be very displeasing to some -- is on the table, is it not?

ASSEMBLYMAN MIKULAK: Everything is on the table.

DR. BROOKS: Because it is on the table, I wanted to pursue with the Commissioner what his reaction is to it. Why he thinks it would be a good idea or why he thinks it would be a bad idea? I'm only pointing out that except for the notion that we have to have a community of sex offenders in one place, there seems to be no reason being given for one or the other.

This, after all, is a person who is at the head of the whole structure and should be able to tell us why.

SENATOR BASSANO: There were reasons, though. Because prior to Avenel, these people who were put into the general prison population were the so-called bottom of the food chain, and they were chewed up by the rest of the prisoners. That was one of the major problems that you had when you placed them into the general population.

DR. BROOKS: Well, you're giving a reason.

SENATOR BASSANO: Secondly, to put all these people under one roof it is easier to treat them, if you're going to provide any type of treatment for them. So that was one of the reasons for the creation of Avenel.

DR. BROOKS: But has that eventuated?

SENATOR BASSANO: Well, I think what has happened is what started out as a facility that should have been treating 200 or 300 people, we just kept throwing people in there. It has gotten out of hand, where the treatment is now secondary and we've turned it into a prison.

DR. BROOKS: I'm going to save my further remarks and questions for when the Task Force gets together.

SENATOR BASSANO: I can see we're going to have a lively meeting when we do that.

DR. BROOKS: I was really trying to address this to the Commissioner. I really was interested in getting from the Commissioner his view about this crucial question.

SENATOR BASSANO: I know you're running late. I'd like to conclude your testimony. I have a note here that you're running late.

What I would ask for you to do, again, as Senator Inverso and Senator Matheussen both asked, please provide us with what you need so that we can then evaluate that when we put together our report? I won't promise you anything, but I can tell you it will be discussed.

COMMISSIONER FAUVER: I understand. I would like to be involved in the discussions, too.

SENATOR BASSANO: May these members, if they so desire -- like Professor Brooks -- write to you to get some written response from you?

COMMISSIONER FAUVER: Sure.

ASSEMBLYMAN MIKULAK: Through the Task Force.

COMMISSIONER FAUVER: Through the Chair?

ASSEMBLYMAN MIKULAK: Yes.

SENATOR BASSANO: If you would be kind enough to answer any response that they have?

ASSEMBLYMAN MIKULAK: Yes, provide the written response to Anne Stefane, and she'll share it with the Task Force and forward it to the Commissioner.

COMMISSIONER FAUVER: That's fine.

ASSEMBLYMAN MIKULAK: That way we can all have the benefit.

SENATOR BASSANO: Thank you.

ASSEMBLYMAN MIKULAK: Thank you.

COMMISSIONER FAUVER: Thank you.

SENATOR BASSANO: Call our next witness, please.

MS. STEFANE: Karen Wengert and Paul Schlaflin.

SENATOR BASSANO: Karen, Paul, I want to apologize. I know you were at the last meeting and we didn't get to you, so I wanted to apologize for that.

Whichever one of you would like to start.

K A R E N W E N G E R T: Thank you.

One year ago, my daughter Amanda was murdered, allegedly, by a previously convicted sex offender. At the age of 16, he molested three children all between four and six years of age. The heinous acts that he committed were not that of an experimenting juvenile, but of an adult seeking sexual gratification. He was slapped on the wrist and given one year of probation and one hour of therapy per week as his punishment.

We need to get help for these sex offenders when they are juveniles, not when they become savage adults. One could only guess whether Amanda would be alive today if the accused, Kevin Aquino, had served time in a juvenile facility.

I have read many articles and have spoken with many different people regarding sex offenders. On the whole, therapists, psychologists, and law enforcement personnel do not believe that most adult sex offenders can be treated and rehabilitated. Most feel that the only treatable offenders are juveniles who are just starting to act on their deviant urges.

One adult sex offender writes, "In many cases, prison intensifies sex offenders' conditions by making us more savage." He continues, "Sex offenders who have been to prison not only emerge with an appetite for violence, but also learn a lesson about how to stay out of jail: make sure the next victim can't ever report them."

We must remember sex offenders are criminals of the lowest magnitude. We must punish them for the heinous acts they have committed by sending them to prison to serve hard time. Only then should inmates who ask for therapy and seem eager to receive counseling be able to participate. There should be no good behavior credits for those who participate.

In our State alone there are over 700 juvenile sex offenders. We have just one 18-bed facility in which to treat these offenders. Spending time and money on sex offenders when they are juveniles could save a child's life.

To reiterate, we need to get help for these sex offenders while they are juveniles. The time for change is now. With the support of the people, and organizations such as The Friends of Amanda Foundation, we can all work together to form a juvenile treatment center that is proud of the work they do.

Thank you.

P A U L S C H L A F L I N: Here in New Jersey, we have been involved with a 20-year social experiment known as Avenel, a program of diagnosis and treatment for adult sexual offenders. A program which has proven itself, as evidenced by the events of the last years, a dismal failure and waste of millions of dollars in State revenues.

We have proven that no amount of therapy, fine arts programs, or coddling will protect our communities upon the reintroduction of violent sexual predators into our society. We have learned that such innovative techniques as masturbation satiation, whereby predators view sexually explicit films and masturbate excessively in an attempt to burn out their deviant desires, do nothing to enhance the safety of our innocent children.

Most troubling to myself and the thousands of New Jersey citizens I have spoken with is this concept that we as a society are somehow indebted, obligated to spend tens of thousands of dollars a year, year after year, in a futile attempt to correct what is broken beyond repair.

What we have learned is that adult sexual predators never lose their urge, their desire to offend again. We know lists of victims totaling in the hundreds is not uncommon for adult sexual offenders. Even more troubling is the fact that all victims, especially child victims, have the potential to

become offenders themselves. This fact most likely contributed to the 711 juveniles arrested in 1993 for sex crimes, including 235 rapes, 10 of which were committed by children under the age of 10.

Although the consensus of opinion of most experts in the field as the best chance of reaching a sexual offender and having a positive impact is early intervention, some say by age 12 or 13, here in New Jersey we have a single 18-bed facility for juvenile sex offenders.

Now, considering it is an 18-month program of treatment and we adjudicate around 1000 juveniles in an 18-month period, we're about 982 beds short of dealing with the problem of juvenile sexual predators, and further, the adult offender, since the juvenile offender of today is the adult offender of tomorrow.

There is nothing, nothing that we can do to guarantee our children will be safe from harm from the 700-plus inmates now at Avenel. We can, however, help assure the safety of our grandchildren by committing to dealing with the juvenile offender now.

A bill recently introduced by Michael Arnone of the 12th District, scratches the surface by adding 30 or so beds. What I would prefer to see is a willingness to accept the chronic nature of the adult sexual predator, to seek civil commitment, and remove, once and for all, the danger of recidivism. This can only occur when the offender is no longer part of our society.

Close Avenel as an adult facility and rededicate the building and the budget to the real problem: the untreated juvenile offender. We can no longer afford to pour millions of dollars into a failed social experiment, while at the same time virtually ignoring the very real problem of juvenile offenders. How do we justify millions of dollars spent on therapy that

doesn't work, and at the same time, ignore the root cause of adult predation, the juvenile sexual offender?

Jesse Timmendequas served six years at this facility, Avenel. The victim of the attack that put him there survived. His first known victim upon his release wasn't as lucky. We buried seven-year-old Megan Kanka seven months ago. We know the outpatient treatment afforded most juveniles doesn't work. Kevin Aquino successfully completed the program shortly before raping and murdering six-year-old Amanda Wengert.

Your Task Force is in a position to affect real and meaningful change, but please don't fool yourself into believing a simple restructuring of treatment will somehow enhance the results. This is not a problem of understaffing; more therapy won't help. You will not find any more success in the records from the beginning of this program than we have now.

Further, I would like to state that after sitting through the six hours of testimony at the meeting February 1, I was appalled. It was quite apparent to me, after listening to the administration and therapeutic staff, that Avenel is operating in a state of utter chaos: administrators mandating programs against the advice of those who should best understand needs, whistle-blowing therapists accusing each other of misrepresentations to this Task Force.

Megan's Law was also referred to in testimony. First, let me say I became involved, and was pursuing in the Legislature, Megan's Law five months before Megan was murdered. I take great exception to anyone trying to put a negative spin on Megan's Law; there is none. This law, in my opinion, based in simple common sense, will help identify the offender who accepts his problem and wants help.

An alcoholic truly concerned with his rehabilitation would have no problem with the neighborhood bartender knowing not to serve him. Why wouldn't the pedophile want me to know not to leave my two young sons alone with him? That is, if he

was serious about avoiding a regression, which I believe was the term one therapist used to describe a rape by a treated and released sex offender.

I don't, however, believe it was the same therapist who suggested that society is somehow to blame for not hiring a kinder, gentler, more compassionate prison guard. Perhaps we should consider engaging the services of a gentleman's gentleman for each of the Avenel inmates, thereby raising their self-esteem to a level whereby they would feel comfortable participating in therapy.

I submit to this Task Force that under ideal conditions, in a utopian environment, an extremely small segment of the very large population of sexual predators will gain significantly from therapy and none will be cured. Further, Avenel is as far from ideal conditions as one could get. By the Director's own admissions, no state of the art exists; however, at Avenel anarchy certainly does.

I challenge the members of this Task Force to take the only logical course. Have the courage to say what you know in your hearts is true; there is no hope for the adult offender. Therefore, we can no longer justify our resources while at the same time the real problem and solution -- juvenile treatment programs -- go, for the most part, unfunded.

If we fail to act now, if Avenel is not closed and the program discontinued, I feel that we will all have to accept part of the responsibility and the guilt for any further acts of recidivism.

Thank you.

SENATOR BASSANO: I thank you for your comments. Let me first point out that the Task Force that is before you was not charged to look at the juvenile offender. We recognize that is a very major problem. The Governor's Task Force just issued a report dealing with juveniles in general.

One of the things that I envision coming out of this Task Force is the creation of a permanent Commission on Avenel and on sex offenders. I certainly would include as part of the charge to that Commission to look at the juvenile offender and how we're going to deal with that offender. Should that offender be in Corrections? Should they be in Human Services?

You're absolutely on target when you talk about the number of beds, or the lack of beds, that we have in this system and the need for additional help for that offender. But, again, as I said, we were not charged to handle that particular problem. Some of the other comments that you made are well-taken, and we will certainly take some of the comments that you made into consideration as we put together a report on Avenel and how we would improve the system as it presently exists.

ASSEMBLYMAN MIKULAK: I agree with many things that you said, and we've talked about this in the past. But I still don't understand what makes you think-- If we took a 700-person population, a large facility for sex offenders -- that I acknowledge is disfunctional -- and closed it and then created a 700-bed facility for juvenile sex offenders, duplicating what is not working now, seems to me to be a recipe for failure. That is not workin .

The Pinelands is smaller. It's outside of this Task Force's purview, but it seems to have a better effect. I would consider replicating that in a number of places. I would consider putting money into that. But the last thing in the world that I would want to see would be an Adult Diagnostic Treatment Center for juveniles that size -- a big institution.

MR. SCHLAFLIN: Well, again, I'm talking about the building itself. It would have to be utilized, again, as 700 beds. It was my understanding that it was originally built to accommodate 300. Certainly, we could set it up to accommodate small pod groups of juveniles.

SENATOR BASSANO: This is what we're talking of doing; taking people out of there who are not willing to accept treatment, people who are long-term prisoners, and putting people in there where we can increase the success ratio. This Task Force recognizes that we are never going to be 100 percent successful with all the sex offenders who are out there.

We think if you achieve an 80 percent success ratio, that success ratio would go back on the street. The other 20 percent who can't be helped or refuse help, never let them out of the system. They have to stay there indefinitely. I think if we start segregating that way, we're going to have a more successful system. But that is what I think you're going to see coming out of this Task Force in the recommendations that we will make.

I don't want to go on. I know Senator Inverso had a question or a statement.

SENATOR INVERSO: I think you're absolutely right on target when it comes to dealing with juveniles. The one thing that has emerged for me since the tragedies that have occurred in this State -- with your child and Maureen Kanka's child -- is that while we need to look at Avenel, which we're doing, we have disregarded, almost ignored the need to deal with youth who are sex offenders.

I have made it my personal commitment, as far as the Budget Committee that I serve on, to make sure that we deploy resources for either a replication of Pinelands or other programs. I recently -- in the past week -- met with Catholic Charities in the area. They have a youth/juvenile sex offender program that is in need of funding. If they can continue to operate on the basis that the program can achieve the goals that it has laid out for itself, I've committed myself to seek those funds in the budget.

But you are absolutely right bringing it to the table at this point in time. We're all aware of it as a result of

this process. If we ignore that need, then, indeed, we shirk our responsibilities to, as you said, our children and grandchildren, because that is where the real problem will be if we keep ignoring the fact that juveniles will grow to be adults. At that point in time we have lost the battle, we really have, and lost the war.

Thank you, again. I know how difficult it is for you to come before us on this issue, but I want to commend you and Maureen Kanka for taking the tragedies that occurred in your lives and trying to make it better for others.

SENATOR BASSANO: Absolutely.

Thank you very much.

MR. SCHLAFLIN: Thank you.

SENATOR BASSANO: We're going to have one more speaker before we break for lunch. This person has a scheduling problem so we want to get this person on before we break.

MS. STEFANE: Rob Freeman-Longo, the Safer Society Program.

SENATOR BASSANO: We thank you for coming to New Jersey.

R O B E R T E. F R E E M A N - L O N G O: You're welcome.

SENATOR BASSANO: Perhaps you may want to give a brief background of yourself before you get into your testimony.

MR. FREEMAN-LONGO: My name is Rob Freeman-Longo. I currently codirect the Safer Society Program and Press in Brandon, Vermont. The Safer Society was founded approximately 20 years ago by Fay Knopp. Our primary mission is the prevention and treatment of sexual abuse. We're a national information referral center on this issue. We publish books, several of which I have written myself.

We collect data, and we have some data, which I'm willing to share this morning, that is pretty much unique in the United States if not the world. We're the only agency that tracks what is going on in sex offender treatment; that is, what

the trends are, what seems to be working, what seems to not be working, what modalities are most widely used, etc.

I've also got a background-- In addition to working at Safer Society, for the past 17 years I have treated both adult and juvenile sex offenders in correctional settings, state hospital settings, and in the community. I currently do work part-time as a contract person providing treatment to juvenile sex offenders. So I think that is a pretty quick background.

SENATOR BASSANO: Feel free to continue.

MR. FREEMAN-LONGO: Okay. The sense I kind of have as to why I'm here is to talk a bit about what seem to be the trends in treatment, to maybe address a little bit about Avenel, which I am somewhat familiar with, and then maybe answer some questions.

I have not made a personal visit to Avenel, but became quite familiar with that facility when I first began working in this field, because the Director at that time, a man named Bill Prendergast, was running that outfit and came down to Florida where I began my career working in this field. That is how I became familiar with it.

At that point in time, certainly back in 1978, when the United States had identified approximately 25 programs in the country treating sex offenders, Avenel was considered to be somewhat of a leading model and program.

Today, the Safer Society has identified well over 1700 programs, which is based on a 65 percent return on questionnaires. So I'm here to tell you that the existence of programs in the United States, from just about 15 years or 17 years from the first beginnings of our surveys, has grown considerably. That is to say, there are well over 1000 programs treating juveniles in this country. There are well over 1000 programs treating adult sex offenders in this country.

For the first time we have begun tracking programs treating what we call "abuse reactive children"; that is, four-,

five-, and six-year-olds who have been sexually abused and begin to act out sexually. We don't label them as predators. They are sort of modeling that behavior, and we would hate to refer to those poor kids as sex offenders, at least right now.

The little bit I have gained from reading one of the reports done by a Dr. Nancy Steele, who I am familiar with -- she is a NIC consultant, as am I -- indicates that there certainly are some problems with Avenel.

When I heard this morning -- having come in about an hour ago -- about an hour and a half of therapy per week, that certainly is not something I would label as therapy. People referring to use of certain types of behavioral techniques that are slowly waning, as new models and techniques come into existence, would indicate that, certainly, that program, if it is going to continue, should be revisited. Have a couple of consultants come in who are much more in tune with what is happening at a national level with the data to support what is happening in their programs, and maybe look at revisiting some of the techniques.

A staff/client ratio of 30 people in a group is way too high. You're not going to have success with 30 people in a group. The standard around the United States for treatment would probably be 8 or 10 to a group, 12 to 15 at a maximum level, and for a group therapy session, it should be no less than an hour and a half.

In a residential program, if you're spending twenty-some-odd million dollars, you should be getting about 40 hours a week of therapy. I'm not sure where all that money is going to, but for an hour and a half of group a week, you're paying a lot of other people to do something that-- I'm not sure what's going on, but that is not enough therapy for that kind of money.

The argument about juveniles and adults -- this is on adults -- I'm not going to side one way or the other.

Certainly, treating juveniles is a very useful thing. I would say that we have to think in terms of what are the options if you choose not to treat this population, be they juvenile or adult?

The options simply will be that if you choose to discontinue treatment of sex offenders, you will be faced with having to keep them incarcerated probably the rest of their lives. If you're looking at an average 30-year sentence, we're talking about $1.3 million every time the judge slaps down that gavel. According to research done in 1992, your costs for incarcerations for 30 years to keep one bed filled, not a prison but one bed, are $1.3 million. So we can treat people a lot cheaper than we can incarcerate them.

But I think what you have to think about is, you think about treatment; not every sex offender is treatable. Unfortunately, what happens, in the cases of Amanda and Megan, is what gets the national attention are these horrendous crimes. I'm very sorry about those individuals, and there is nothing we can do to get those individuals back, but that is not representative of who the average sex offender is.

The average sex offender is somebody known to the family. The average sex offender does not murder their victim. The average sex offender can be of any background, any race, any socioeconomic status. It is not a lower class phenomenon, per se. I have colleagues who are now treating physicians. I have colleagues treating other professionals. If you've read the newspapers, you know that we have clergy. I'm putting on a special conference to deal with the issue of clergy. So it can be anybody. It could be people in this room. So we have to think of this as a problem that is not just going to go away, and we have to think about how we might best work with the problem.

As I said, you need to assess the problem. Not all people are treatable, regardless of the infliction. This

country spends billions of dollars a year on alcohol and drug treatments, and with the more difficult alcohol and drug clients, your success rate is about 10 percent.

So when I hear success rates of 17 percent, I begin to say that sounds pretty good compared to some other populations that I would want to know what their outcome is. What is the outcome of treating marital problems? What is the success rate of marriage therapy in America? What is the success rate of treating depression in America?

There is no cure I'm aware of in any field, any realm of mental health. There is simply not a cure. What we give people who have mental health problems are tools. The person chooses to use the tool, the person chooses to not use the tool, that is what makes the difference. With sex offenders, you need additional supervision. You need additional community monitoring. I think that is certainly important. We've demonstrated that that will be very effective in working with these people, but you're not going to treat them all and treat them all successfully.

Is that a question, sir?

ASSEMBLYMAN MIKULAK: I had a question-- You alluded to Nancy Steele.

MR. FREEMAN-LONGO: Right.

ASSEMBLYMAN MIKULAK: I had received the report by Nancy Steele that she did on Avenel only after much questioning and argument with the Department of Corrections and after an AP reporter called me up and told me that they had already changed the program.

The problem that I had with that report is that it was very superficial. It was like a feel-good report. Nancy Steele went down there for a couple of days, and then, in her report, she starts with the assumption that the program is good in Avenel, it's one of the best in the country, and it's not.

MR. FREEMAN-LONGO: Right. I would disagree with her.

ASSEMBLYMAN MIKULAK: If they followed her recommendations, which they did, it will be a much better program. But I think you start-- I don't think it was adequate at all.

MR. FREEMAN-LONGO: It's not a good report. As a matter of fact, she doesn't even allude to-- She talks about the current, sort of, state of doing assessments. There are two assessment tools that literature clearly tells us that we can determine whether somebody is going to respond well to treatment or not, what the outcome will be. Are they likely to be recidivists after treatment or not? They're not even mentioned in this report.

MR. MULLER: One point if I may?

MR. FREEMAN-LONGO: Yes, sir.

MR. MULLER: You referred to a 17 percent success ratio?

MR. FREEMAN-LONGO: Someone said that earlier.

MR. MULLER: No, no, no. They're referring to an 83 percent success ratio and a 17 percent failure ratio, which I think if you inverted it, it would be closer to what--

MR. FREEMAN-LONGO: I inverted it and I am sorry. You're right, I understood it to be 83 percent success--

MR. MULLER: The inversion is more accurate.

MR. FREEMAN-LONGO: --and that's not a bad success rate.

MR. MULLER: The 17 percent?

MR. FREEMAN-LONGO: The 80 percent.

ASSEMBLYMAN MIKULAK: A closer look at the statistics says that the 17 percent are reincarcerated; that is, caught, convicted, and reincarcerated, so that is really not that accurate.

MR. MULLER: There is another misnomer I mentioned to you earlier. The Commissioner sat here and used the term "first-time offender." First time caught--

MR. FREEMAN-LONGO: First time caught.

MR. MULLER: --the average is 11 victims per first time caught before they're apprehended. So let us not forget that before we got the first time caught, this person had been in an obsessive-compulsive behavior pattern before that -- 11 times on the average. That is a significant number.

MR. FREEMAN-LONGO: Yes, and someone mentioned the California program and the Virginia program. The Virginia program isn't-- That is not good research. California is good research, and their research doesn't show a lot of differentiation between treatment and nontreatment at this point in time, but the study was cut off. I know those people really well.

I can also tell that when you do pure research like that -- and you have a professor here who can probably attest to that -- once you start the plan, if you discover that you are doing something horribly wrong, you can't change it. So they knew going into this project, within a couple of years, there were things they were doing that could be changed to give better outcome, but because of the design of the project, it was left as it was. So the research is only as good as what they're researching on is done. If new techniques came in, if they could have changed the system around-- They couldn't change it midstream in their research.

There are other programs such as Vermont's, which is showing very good outcome. What we can tell you, looking at national studies--

I have three or four documents I will leave with Kate, on this. You can Xerox them. They are all ours, you're not going to be in violation of copyright law. I can't authorize you copying this, "The Standards of Care," which I'll leave, but the three articles that we published I will, and our nationwide survey is one of them.

We can tell you that your best outcome is with incest offenders. We see programs shooting 90 percent, 95 percent or better success rates: with pedophiles, who are more likely to assault girls than boys, we have a pretty good outcome, in the 90s; with rapists we have a lot less good outcome; and for the unfortunate cases where someone is raped and murdered, nobody even wants to treat those people, so we don't have any outcome. If someone is prone to murder, people don't even want to touch them. Unfortunately, that is where we are going to learn the most in the field in terms of research, working with the throwaways.

MR. MULLER: You didn't mention the rapists of little boys, what is that percentage?

MR. FREEMAN-LONGO: Somebody who molests and rapes boys, by most studies, is going to recidivate more than somebody who molests girls.

MR. MULLER: Substantially more.

SENATOR BASSANO: But what you're saying is that we have to segregate. Am I correct in that assessment, that you have to segregate as you provide treatment, and some people you can succeed with and some you can't?

MR. FREEMAN-LONGO: No. I'm not saying you segregate them in treatment. What I'm saying is, we can tell you who is more likely to respond to treatment and who is not going to respond as well. Rapists, you may be seeing 70 percent to 80 percent success rates; certain pedophiles, 90 percent.

Does that mean the Task Force says, "Okay, we won't treat rapists, we'll incarcerate them, period"? That is up to you all. I'm just telling you what the data says, and then those are decisions you all make.

SENATOR BASSANO: But if we put, let's say, rapists, as an example, before a group of psychiatrists, they should to some extent be able to judge, based upon treatment, who they think can function out there in society and who can't, and those

who can't, if we keep those people incarcerated, we're going to have a successful system?

MR. FREEMAN-LONGO: Yes, if you do good assessment on the front end and determine who is more likely to respond to treatment versus who will not respond as well, you will have better treatment outcome, there is no doubt about that. What I was just suggesting is, here is what the data tells us today about who those success populations are, who the more difficult populations are, and who the populations are that nobody wants to treat.

So, I mean, pedophiles seem to be a more desirable population to treat with a better outcome. Rapists are a less desirable population with a worse outcome. Rape/murderers, nobody even wants to bother with those people.

So, again, you have so many dollars and I haven't been to a state yet-- I have consulted around this country; I've trained around this country; I have consulted overseas, and they're no different over there in New Zealand, Australia, and in Canada than they are in America. There is never enough money in any state that I have ever been to, or country, to treat every single sex offender.

One of the sad things about this is there are men who are dangerous, some women who are dangerous; they don't want your treatment. They're going to be appealing their cases. They don't want to be a part of a program. You know they're dangerous, and those are people you're probably not going to want to spend your resources on. You just can't treat them all.

SENATOR BASSANO: What is happening now is, they are maxing out in our system, and with the system we have, they end up back on the street. They walk away free and clear.

MR. FREEMAN-LONGO: That is predictable that they will reoffend.

SENATOR BASSANO: That is where I think our major problem is.

MR. FREEMAN-LONGO: Right.

SENATOR INVERSO: May I ask a question?

SENATOR BASSANO: Yes, go ahead, Peter.

SENATOR INVERSO: Have you seen the profile of the inmates at Avenel?

MR. FREEMAN-LONGO: No, I have not. No, I haven't.

SENATOR INVERSO: I was wondering whether, if you had an opportunity to see that, if you could proffer us as to whether or not we have a category in there who are not treatable. As you said earlier, there are some who are treatable, there are some who are not treatable, and you gave us this success ratio here. I'm just wondering what the composition of Avenel is relative to your assessment of what you think is treatable and untreatable?

MR. FREEMAN-LONGO: I could guess at it, Senator. Having been to other states, probably 70 percent of your population at Avenel are pedophiles, probably 70 percent. Of that 70 percent, probably half of those are men who tend to focus on molesting male children -- not necessarily exclusively, but that is their primary target -- the other half probably female children, and of that percentage there is going to be, certainly, some who are incest offenders who molest their own kids.

SENATOR INVERSO: But if 70 percent are pedophiles, without discerning between whether it is female or male pedophile types, you say there is a 90 percent success rate?

MR. FREEMAN-LONGO: For pedophiles who tend to molest their own children and who have female victims, yes, sir.

SENATOR INVERSO: So, to that extent then, you would think, you would say that the population at Avenel is in a treatable category because of the very high success rate you have with pedophiles?

MR. FREEMAN-LONGO: I would say that there is a percentage of inmates at Avenel who will respond quite favorably

to treatment. There is going to be a percentage -- I don't know what that is -- who will be totally nonresponsive to treatment, and there is a going to be a percentage who are going to be somewhat responsive, but you may need to put a lot more tighter controls on those people when they are released.

SENATOR INVERSO: That is a given, but you're saying within-- If for arguments sake, some of the inmates are pedophiles, and let's say they're all pedophiles who perpetrate their acts against females, there is a 90 percent success ratio?

MR. FREEMAN-LONGO: Potential.

SENATOR INVERSO: Could I then infer that you're saying, to that extent, at least 70 percent of our population at Avenel would have a high success rate, should be there, and should be subject to the therapy that they provide?

MR. FREEMAN-LONGO: Based on what you see there, that breakdown, yes, that is what you see.

Now, what we haven't talked about, that I was alluding to earlier--

SENATOR INVERSO: The answer is yes, though?

MR. FREEMAN-LONGO: Yes.

SENATOR INVERSO: I'm just trying to get a handle on--

MR. FREEMAN-LONGO: There is a 70 percent potential treatment pool right there, just without looking one iota further at them.

But do understand, Senator, that of that 70 percent, there is going to be a certain percentage who don't want treatment or who have such lengthy histories and have done other criminal crimes and things that-- For instance, the Hare Psychopathy Checklist will identify that, will tell you right off the bat, "Forget this guy. He is not worth, given our limited resources in our State, treating," and I don't know what that percentage would be.

SENATOR INVERSO: Absolutely.

SENATOR BASSANO: Can you tell me that before I start treating him, if you were to look at his background and do a psychological workup on that individual?

MR. FREEMAN-LONGO: The data suggests, at this time, that if you use the Hare Psychopathy Checklist, in conjunction with phallometric assessment -- and now there is a new measure out, developed by Gene Abel, that doesn't require using the penile plethysmograph as a tool. It is another tool that measures arousal without all the hookups to the genitalia.

If you use those two assessment procedures together, you can pinpoint much more accurately which of those people in that pool of potential treatment candidates are likely to respond to treatment and those who are most likely to succeed at it. Just those two tools are showing very, very good favorable promise.

ASSEMBLYMAN MIKULAK: Is that just for pedophiles or is that for violent rapists too?

MR. FREEMAN-LONGO: That would be for the whole lot of them.

DR. BROOKS: May I ask this question? What is the attitude of persons like yourself, who are so expert, about the use of Depo-Provera as an additional chemical treatment, especially for pedophiles? I realize it is not successful in the case of rapists, but where it is supposed to be successful is for pedophiles. Do you recommend it, and if not, why not?

MR. FREEMAN-LONGO: Sure. I recommend the use of drugs like Depo-Provera when you have a client who is engaged in treatment and wants to change. Because, at least in the people I know who are leading researchers with that drug, like Fred Berlin at Johns Hopkins, it is equated to a diet pill analogy. It's like, you can take a diet pill and gain weight. It doesn't stop you from eating. It helps curb your food appetite, but it doesn't stop you eating. Depo can, if the person wants the change, curb the sexual appetite. But we have had clients who

have been on that for a year, they don't want to change, and nothing happens.

There are better drugs out there, some that aren't legal in this country yet. I think one that is being experimented with, but in Canada and overseas, is Cyperterone Acetates. It is a cleaner, faster, better drug. There are some other drugs that are currently being used. I could steer you in the direction of some physicians, which I am not one, who could better talk to you medically speaking than I can, as a masters level person, about the medical implications, the use, and the effects. But there are some other drugs being used that are showing good promise to curb that sexual drive with less side effects, mind you, than the Depo has.

DR. BROOKS: I gather from what you said earlier that assessment tests can be used to determine whether a particular sex offender is, in fact, amenable to treatment? Would you recommend that one change that the Task Force might consider is, if the current statute were retained, that there should be an addition, namely, that the offender under consideration should be regarded and found by the judge to be amenable to treatment? Because that currently is not in the legislation, the judges keep sending sex offenders to Avenel without even thinking about whether they're treatable or not.

MR. FREEMAN-LONGO: Yes, okay, in that regard, in the ideal system. When we look at how a system might work in any given state, what I would recommend and we've seen happen in other states is, really, the assessment should happen presentencing.

DR. BROOKS: Yes.

MR. FREEMAN-LONGO: Because not every pedophile deserves 30 years. Now, California, which has a 25-year minimum sentence for pedophilia in certain cases, is wasting a lot of money because there are people who are the, so to speak-- Well, we don't say first-time offenders, but first of record, low

numbers of victims. They got caught pretty early on. They're highly motivated. They can be very safely treated in the community with good monitoring and save you a lot of bucks. That should be determined presentence.

But then there are those people who have multiple victims, a lengthy history, don't want treatment, they're in denial, whatever, or through use of the Hare and other instruments, might be determined to be less amenable, much greater risk; they belong incarcerated.

There are going to be some people who you just say, "Hey, if we're going to give long sentences to keep the community safe, then maybe this is the person here because they just aren't going to respond." Although, as somebody who I consider to be a humanist -- myself, that is -- the door could always be open for them to go through a reassessment at some point in time and then into an institutional treatment program. I hate to slam the door on people because the criminal justice system puts you in a mind state of saying, "I'm innocent," and the whole nine yards.

But, yes, at the front end, that would save you money, and I think the person should be required to pay for that, not the State. I think the individual, through their own resources, should come up with funds. Then there are always those cases where they are indigent, and that is where you use State funds, you have sliding fees, or you use the clinicians who do pro bono work like some of us do.

DR. BROOKS: Could you comment on the philosophy that even if the sex offender resists treatment, refuses treatment, that you should just keep trying, if necessary for years, and that sooner or later, if you lead that particular horse to water, he will drink?

MR. FREEMAN-LONGO: He might.

DR. BROOKS: That is the prevalent philosophy at Avenel, and they regard refusers as potential acceptors. They

just want to keep them there long enough until they change their minds and say, "Hey, I want treatment now."

MR. FREEMAN-LONGO: What we did in a couple of states I worked in and consulted with is, of people who went to prison, all sex offenders were placed at a particular facility for an orientation and screening phase. Basically, what that was -- to get to say this quickly -- was, "This is your life as a sex offender in the State of New Jersey. Here is what happens if you stay in prison. Here is what is going to happen when you get out," and they laid out all the parameters. "When you get out, whether you have been through treatment or not, you're going to be under these laws. You're going to be monitored. The difference being is, if you have to be in treatment out there when you get out in 10, 20, or 30 years, you will pay for it, the State will not. "While you're in prison these are your options for treatments."

Then you screen those people who are amenable versus nonamenable. But for the people who were the deniers, I think they certainly can be revisited through a mailer. Just say, "The door is open for you if you want to change your mind."

But I don't understand this totally, so correct me if I am wrong, they don't need to be kept at Avenel. I did hear somebody talk about the pecking order in prisons. Yes, there is a pecking order in prisons. Yes, sex offenders are at the bottom. But that is a choice you make when you commit a sex offense. That is a choice when you go to prison and turn down treatment, and that is just life on the farm, honey.

DR. BROOKS: Right.

MR. FREEMAN-LONGO: If you want to be in treatment, then that requires that you admit that you have a problem, you need help for it, and you go along with the program. If not, then I'm sorry about that. If you're appealing your case, you have that legal right. Yes, you do, sir. But you cannot stay

in this facility that costs $25 million a year for us to house people. You can go to a general population.

SENATOR BASSANO: I think this Task Force is also taking the attitude that there has to be some incarceration in a general prison facility prior to receiving treatment for many of these people. They have committed a crime. They have to pay society back for the commission of that crime. Then, and only then, will they be allowed the privilege of getting treatment before there is a release.

MR. FREEMAN-LONGO: Yes, Senator.

SENATOR BASSANO: I think that is the sentiment, though, of this group.

MR. FREEMAN-LONGO: Senator, if your laws provide for a minimum length of incarceration for the average sex offender, let's just say -- I don't know them and I apologize for not knowing them -- it's 10 years, and your program at Avenel were designed to be a, say 18- to 30-month program, more than ample time. The average length of treatment in an intensive residential program in a prison in America is about 18 months to 2 years.

I read somewhere in Dr. Steele's report something about five years, and I thought, "My God, you're burning them out." You can burn out on therapy too. Well, if that is the case, then yes, during that last two to two and a half year period is when they have signed up, and they go to that facility.

Now, there are pros and cons to all of this stuff. Yes, the correctional sort of lifestyle will harden people. It will make them have to learn all the survivor and con games. But I have worked within a correctional system, and those men who do want to be involved in treatment have other options. I would imagine in the New Jersey correctional system there are alcohol and drug programs, other sorts of treatments, educational opportunities. You keep yourself busy. I have had

guys who have, through a series of unfortunate events, gone through treatment for two years, gone back to a prison for two years, still got out, and they're doing well today.

There is certainly some myth that if you don't hit them right away and put them in a special sort of category and special institution you're going to lose them. You can't afford to do that. I'm an advocate for treatment. I don't think it works, I know it works. I also know that there are studies that suggest it is effective. Like I said, I know of no mental health population that does have a success rate of 100 percent, I don't care what the mental health problem is.

You can keep them in an institution, keep them busy. You can even do some education groups that are pretreatment groups to keep them occupied until they go to the intensive program. That is where you will save money. That is where you will maximize your dollars.

SENATOR BASSANO: I have to reiterate, though, that society will not be satisfied with a three- to five-year prison sentence for someone in an intensive program at Avenel. Society feels there is a crime that was committed; society wants that there be some restitution, and that restitution is through some type of incarceration.

MR. FREEMAN-LONGO: I'm not disagreeing. I'm saying they would be in a regular prison, and then they would transfer to a correctional facility where you would have your program, i.e. Avenel. But if they're not engaged in treatment, they don't need to be at Avenel.

SENATOR BASSANO: Absolutely.

MR. FREEMAN-LONGO: I think you make another point as we--

SENATOR BASSANO: I just want to interrupt you for one second. I think also those people who potentially show that they are not going to respond to treatment should not be put into Avenel. That is what we want to talk about also. If a

person shows on whatever tests are given that they are potentially not an individual who is going to respond well to treatment, why waste the bed? Why waste taxpayers' money?

MR. FREEMAN-LONGO: I would agree with you. I think if Avenel is a treatment facility, then that is what should go on, period, end of quote. You can use any variety of models where they can still have their institutional jobs and keep the facility running. You don't have to hire your gardeners and plumbers to come in; the inmates can do that. I am protreatment, pro everything.

But I think a facility with 700 people and you're trying-- I think they have an impossible task right now.

SENATOR BASSANO: What we've done, unfortunately, is create an institution, a jail, for sex offenders rather than a facility to treat sex offenders prior to them being released into society, if the potential is there for them to function normally.

MR. FREEMAN-LONGO: I don't think you want to know the bill of what it would cost your State to treat all 700 of those people and treat them well. It's a very, very high bill even in a correctional setting.

But if you had a program that was even 200, just 200 men, which is a large program in the United States -- that is a very large program -- then you probably have adequate resources to do a damn good job and provide what is, and there does exist, state-of-the-art treatment.

We're going to give you an article on that and the data that shows what does happen in this country. You can have good outcome data, but you really need to have a good plan and a system that looks at who is going to best benefit from this limited pool of resources.

SENATOR BASSANO: We have to be very selective on who is going to go into the program?

MR. FREEMAN-LONGO: That is my recommendation, yes, sir.

There are good screening tools. There is data that suggests what is more effective with these types of individuals. I was going to say, you made a point earlier, that you are never, as we track what is happening in this country, you are never, as a legislative body, going to make the American public happy, because Americans are fed up with crime. They don't want to hear about treatment. They don't want to see criminals "coddled," and treatment has gotten a bad name in light of all the recent crime and hype about what is happening in America. So you are never going to please those people.

What you really should do is take some of those dollars -- and I say this to every single legislative body I talk to -- and advocate some of those for a university nearby to hire and pay a small price for those graduate students so inclined to do research. You don't have to have a full-time Ph.D. staff researcher on your staff.

A department of psychology, if you said, "We will give this department $5000 or $10,000 to do research on this program as an independent body," I can assure you-- You could lock me up if you don't have a couple of Chairs saying, "We would love to have that money. We will provide you with the graduate students who will come in there. We will pay them a nice stipend to do the research." They keep the data. They analyze the data. They give you the reports, and you track what you are doing in your State with research not emotion.

What is driving law and criminal law today is pure emotion. We don't think logically when we're emotional. Logically, we know that you have to do something with the problem, and you can't just do lifelong incarceration unless you're going to pay a lot more tax dollars. They're going to get out at some point in time, so the question is: Do you treat or not treat while they're incarcerated, since at some point

they're going to get out? I think the logical answer is, "Yes, you do. But how do we best utilize those funds and is it working?"

There are two types of evaluations. Nancy Steele's report alludes to one. One type of evaluation is called process evaluation. Is the treatment you are doing having any impact on the inmates? When they go into an anger management course, what is their knowledge? When they get out, have they gained something? What is the long-term impact? Have they retained that information through periodic testing that your students at a college could do?

The other type of evaluation is outcome evaluation. That is your recidivism stuff. Now, I didn't see anything in here, although, I know her philosophy is all you need is two years of outcome evaluation. Do it and don't put a cap on it. What you are going to find is, you will find your recidivism will go up a little bit every year, because you have a population sample that will keep on being added to that, but it will then level off over a period of several years, and that is your recidivism rate. You're going to have it.

If you think you're going to cure every single person walking in the door of that facility, you're fooling yourselves, your public, your constituents, and everybody else who is all upset about this problem. You're going to have recidivism. It's how can you minimize it and how can you maximize your dollar, period. That is just the honest-to-God truth.

I'm going back to Vermont tonight. You know, I'm not going to have to sit here and deal with your decision. But I also know that if I'm going to have a sex offender move in next door to me, and someday that will probably happen just by odds, or live on my street, I would rather have somebody who came out of that program than not. Okay?

I'd rather have somebody who has learned something about themselves, has made an effort to change, and through

proper diagnostics and treatment has been given the best odds of succeeding, versus somebody who has come out of prison, has maxed out his term, has minimal supervision, and just a law that says you register. Because they can register wherever they want to, that is not going to protect me in my town from the guy three towns over who I don't know, who will come to my town.

SENATOR BASSANO: What about aftertreatment, a mandatory continuation of therapy once they are released?

MR. FREEMAN-LONGO: A minimum of one year, they pay. I would suggest, if you have the funds to do it, that your follow-up supervision of probation and parole be a minimum of probably two to five years. The first year they should all be at the highest level of probationary supervision, regardless of their progress within the program and in the community. They should be seen once a month with that parole officer for more than five minutes.

SENATOR BASSANO: But do you think at some point in time there is no need for aftercare, or are we dealing with people who are like alcoholics who have to go to AA for as long as they live?

MR. FREEMAN-LONGO: Well, I think there are certainly some sex offenders who will need some sort of ongoing involvement in some level of therapeutic activity that your State can ill afford. But there are, certainly, groups; much like there is AA, there are groups. In a large community, for instance, like Trenton, there could be a lot of, sort of, self-help groups where these guys meet. Practitioners will donate their time to go to the group once a month and just be there as a professional person to assist.

But during the key part of release, that first year or two is very difficult in terms of transition. It becomes more difficult when somebody has been incarcerated for a period of time, because our society is rapidly changing and all those odds of being an "ex-con" are against them. So they are going to

need close supervision. They're going to screw up. They're going to make mistakes.

SENATOR BASSANO: So we would probably be better off allowing the Parole Board a lot of discretion in this area insofar as the requirement for aftercare and the amount of aftercare based upon what the psychiatrists tell us, based on the individual?

MR. FREEMAN-LONGO: Yes, sir. But I would recommend a bare minimum of, like I said, at least one year of aftercare and at least two years of parole supervision, and during that first year of aftercare, that it is very close parole supervision.

The other issue -- not to get off on a sidetrack -- related to that, of course, is when you have high case loads for a parole officer who can't supervise well, that becomes a problem. You see, relapse prevention as a model provides certain components of the public notification laws that we're seeing go up -- like you've seen in New Jersey.

What we say to that offender is, "There are people you must notify, and we will make sure know that you are a sex offender, like your employer, your landlord, and other key people. You are going to have to have this, sort of, supervisor check in with your PO once a week or once every couple of weeks, or with your therapist. Then we're going to talk and see how you're doing." That takes more than 10 minutes a month. So you do want to do that.

But rather than incarcerating somebody forever, which is much more costly, when they are going to get out, put your dollars into that sort of supervision for one to two years minimum. That would be, at least based on what we see happening today, what I would recommend to you.

SENATOR BASSANO: Does anybody have any questions?

ASSEMBLYMAN HOLZAPFEL: I have one question, Senator.

You are the gentleman that was involved in the Oregon program?

MR. FREEMAN-LONGO: I used to direct the Oregon program, yes, sir.

ASSEMBLYMAN HOLZAPFEL: In that program, the typical offender attended inpatient treatment for two to two and a half years, then moved to a prerelease status for six months, work or study by day and return at night, is that the way you did that?

MR. FREEMAN-LONGO: Yes, sir. That was done in the early stages. Ultimately, with changes in law and the fear of the hospital being sued with transition, they just went out the door, and the six-month transition stuff was brought to an abrupt halt.

ASSEMBLYMAN HOLZAPFEL: Then you had outpatient aftercare for 18 months after release, receiving group counseling twice a week at first, and then generally decreasing visits to twice a month?

MR. FREEMAN-LONGO: Yes, sir.

ASSEMBLYMAN HOLZAPFEL: That was the program in Oregon?

MR. FREEMAN-LONGO: That was the one I directed. In that model, as you describe it, in that report was what was happening up until about 1985 or 1986.

ASSEMBLYMAN HOLZAPFEL: Okay. Now, you also wrote an article in "Psychology Today" with a Mr. Wall?

MR FREEMAN-LONGO: Right.

ASSEMBLYMAN HOLZAPFEL: Back in '86?

MR. FREEMAN-LONGO: Yes, sir.

ASSEMBLYMAN HOLZAPFEL: You said there you, "believe that sexually deviant behavior is 'deeply ingrained' and most sex offenders need extensive psychological help to change the thought and behavior patterns that lead them to insinuate or force themselves sexually upon other people."

MR. FREEMAN-LONGO: Yes, sir.

ASSEMBLYMAN HOLZAPFEL: Well, what do you mean by -- or what did you mean, I guess, by -- extensive psychological help? Because I'm getting the sense that you have the feeling that after a short period of time, just a couple of years, that these people can be released.

MR. FREEMAN-LONGO: I think when a person is placed into a program-- What I meant by extensive was what we were doing in that state hospital. We weren't screening the cream of the crop. Oregon had a very good system of outpatient treatment, and when they got to prison, they were serious offenders to begin with. We took people that nobody else even wanted to treat in some cases.

But "extensive," meaning that this was not an hour and a half of group a week. These guys were in group twice a day for one and a half to two hours, five days a week; educational classes, one to two a week, sometimes three a week, that were one to two hours each; plus, very significant homework assignments, and other therapeutic activities. So they were in treatment 40 hours a week times 50 weeks, is 2000 hours of treatment a year, times two to three years, is 4000 to 6000 hours of treatment. That would take you a lifetime going to a psychiatrist one hour a week on the streets to accomplish. You couldn't do it in your lifetime.

ASSEMBLYMAN HOLZAPFEL: I guess what I'm trying to get to is I'm not grasping if-- In this article, are you talking about the people who were in that institution or are you talking about general sex offenders when you say, "most sex offenders need extensive psychological help"? That gives me the message that the majority of the 700 people who are in Avenel, in your opinion, need extensive psychological help.

MR. FREEMAN-LONGO: Yes, they do. That is, they need to be involved in treatment, whether it is an outpatient program or, by assessment, a more significant residential program for a period of time.

The minimum amount of treatment I've seen any pedophile go through, if you're looking at a decent program on the outside, is: Let's say the guy gets probation, he is not in prison, you're looking at usually, again, 18 to 24 months minimum, starting off in time, groups once a week, individual sessions once every couple of weeks, some programs/groups twice a week. So you are still looking at two years of treatment, minimum two to three hours a week over that two-year period and that is extensive.

ASSEMBLYMAN HOLZAPFEL: So that's extensive. Does it matter to you, in your opinion -- I apologize if I missed it -- whether or not, let's say a guy who gets a 25-year sentence, whether he gets that extensive treatment the last four or five years of that sentence?

MR. FREEMAN-LONGO: I think you would be wasting your resources to do it at the front end, because then they go back into an incarceration setting, and unfortunately, prison mentality is such that you have to do certain survival things that will go against what treatment has taught you. Treatment is better on the release end.

ASSEMBLYMAN HOLZAPFEL: My last question then is, if you can do it-- Let's assume we decided that we wanted to change the law to reflect that when you receive a sentence from a sentencing judge that a percentage of that sentence will be served in a regular institution and the remaining portion thereof shall be served at Avenel or somewhere else for treatment. Could you give me an idea as to what percentage? Would you say the last fifth of the sentence? I mean it would be a sliding scale?

MR. FREEMAN-LONGO: No, I wouldn't do that, because your sentences will vary. I would say that you establish a program and that a program is a period of time. Let's just say, for argument, it is two to three years. Okay? So you have to figure the maximum end of treatment that person might go

through, which is three years. If he got a five-year sentence, then he needs to be spending 60 percent of his time in treatment. But if he gets a 10-year sentence, he is spending 20 percent of his time. So don't use a percentage.

ASSEMBLYMAN HOLZAPFEL: But you're answering my question-- You're saying that on the outside, within reason, the typical sex offender should receive somewhere around three years of treatment?

MR. FREEMAN-LONGO: Yes. A minimum of 18 months to 2 years is the standard in America. Many people, because they have very, very severe problems, will go an additional six to twelve months, though it might be up to three years for a more difficult case.

ASSEMBLYMAN HOLZAPFEL: All right. So somebody who gets a 20-year sentence, somewhere around the 17th year he should be transferred over? Somebody who gets a five-year sentence, somewhere around the second year he should be sent over?

MR. FREEMAN-LONGO: Yes, sir. Yes, that is what I would recommend.

ASSEMBLYMAN HOLZAPFEL: Thank you.

MR. THOMAS: One question.

MR. FREEMAN-LONGO: Sure.

MR. THOMAS: We've talked about percentages. With a pedophile, an adult pedophile, is there a possibility of cure?

MR. FREEMAN-LONGO: No.

MR. THOMAS: Or is there a possibility of treatment, I mean, help?

MR. FREEMAN-LONGO: I don't believe there is a cure in any sort of mental health, regardless of the problem, pedophile or otherwise. With many, many pedophiles what you have is the potential to treat them successfully and give them the necessary information and tools to prevent themselves from ever reoffending again.

Now, unfortunately, the first thing that went in Oregon's program, when they had a researcher and budget cuts came, was the research, which is why I said to give the money to a university. Because that will be the first thing cut, especially in a correctional center.

You can do your programming in prison. Don't put it in a State Hospital. It will cost you three times the amount of money and you don't need all the headache; keep it in prison. There are people who will respond well, but you really want to assess that, Mr. Thomas, and assess which people are going to best utilize this very valuable and limited resource in your State.

There are people who, unfortunately, are not going to respond. They don't want it. They're going to be in denial. They're going to whatever, and I walk away from those things scratching my head knowing that some other kid -- if that person gets out some day -- is going to get hurt, and I can't control it. But I do have to focus and put the hope on the man who will respond well.

I have guys who still keep in touch. Our agency is a national agency. We get calls from all over the country from family members, pedophiles, and professionals. Some of the guys I worked with even 10 years ago call, and they're doing quite well. So I know that they can do it. They do well, and the longer they're out and keep clean, the better their chances of remaining that way.

But that first year or two of transition will be most difficult, because all the temptations and the lifestyle things will be affecting them and they need very tight supervision. There is no safe pedophile without treatment, I don't care who says what. But there are men whose risks are tremendously reduced, and I would feel comfortable even living next door to me, with a child, if and when they have gone through treatment and done it well.

So that is as honest as I can be.

MR. THOMAS: I want to say that I talked with your office a few weeks ago and they were most helpful.

MR. FREEMAN-LONGO: Good. If you need more help, do feel free. We're a national resource. We appreciate your call.

MR. THOMAS: It was very helpful to me. Thank you.

SENATOR BASSANO: Are there any other questions of the witness? (no response)

I do sincerely thank you. If we have additional questions, I would ask that the members of the Task Force, through Anne Stefane, contact you. We may be calling on you again, speaking to you over the phone for additional help. But we absolutely thank you for being here.

MR. FREEMAN-LONGO: Yes, sir. Kay and Anne have been in touch. We're available to help out as much as we can. We know you have a very difficult task ahead of you. We wish you well.

I think you're making good decisions by doing treatment. Your best decision will be looking how to use that resource for the people who are going to respond to it.

SENATOR BASSANO: I can assure you that we will be back to you for additional guidance. Thank you very much.

MR. FREEMAN-LONGO: Thank you for having me down.

ASSEMBLYMAN MIKULAK: Thank you for coming.

SENATOR BASSANO: We're going to break now for 40 minutes. It is 1:05. We will be back here at 1:45. There are three more witnesses who want to testify. I intend to cut it off at 4:00 regardless of where we are. So please be punctual and be back here at 1:45.

Thank you.

RECESS

AFTER RECESS:

SENATOR BASSANO: If the Task Force will come to order, we'll start moving forward again with testimony.

Dr. Pallone, we welcome you here.

N A T H A N I E L J. P A L L O N E, Ph.D.: Thank you.

SENATOR BASSANO: Please feel free to start. I'm sure other people will be drifting in. I hope it doesn't interfere with your train of thought.

DR. PALLONE: Okay. Let me just make a couple of general observations, Mr. Chairman.

I am a University Distinguished Professor of Psychology and Criminal Justice at Rutgers and have, since 1979, been a member of the Special Classification Review Board, which is a legislatively established body that reviews Avenel inmates with respect to their readiness for release into the community.

We constitute a necessary, but not sufficient, condition for parole. Which is to say that, obviously, the Parole Board is the final decision maker, but a recommendation for release does not go forward to the Parole Board without our approval.

The SCRB was legislatively created in 1947, which is when the initial legislation was adopted. The term had not yet been invented, but it is a clinical dangerousness review board. That is now a term of ours that is widely used at the intersection of the mental health sciences and corrections.

Our rate of paroling from Avenel over the recent past, let's say roughly the past 15 years, has varied between 1.5 percent and 3 percent. Periodically, we are chastised, beaten about the ears, and put down by various folk in offices in this great capital city because of the low rate of paroling. However, we have withstood several challenges, mostly in the Federal courts.

SENATOR BASSANO: That percentage you just gave us, is that total of the total population?

DR. PALLONE: Of the total population, yes.

SENATOR BASSANO: So it is 1.5 percent to 3 percent a year?

DR. PALLONE: Yes, 1.5 percent to 3 percent a year, as against about 25 percent per year in an ordinary prison.

SENATOR BASSANO: What does that figure equate to when we look at the number of people leaving the institution?

DR. PALLONE: You're talking maybe 10, maybe 12 people a year who leave on parole.

SENATOR BASSANO: No, no, no. Versus people who have maxed out.

DR. PALLONE: That, Senator, I could not give you the-- But it is absolutely clear to say that most inmates max out, are not paroled.

Secondly, I guess what brings me to this table is that my field has been criminal behavior and treatment of offenders for the past 35 years. I am the author of two books having to do with the rehabilitation of criminal sexual psychopaths, and am the Editor of the "Journal of Offender Rehabilitation."

As I listened to the discussion this morning, it seemed to me that the discussion lacked some clarity because it was not well-linked to the national discussion of these very issues that has been going on for some time now.

That deals with such issues as, first: Is there such a thing as a mentally disordered sex offender or criminal sexual psychopath that is, in any way, distinguishable on the basis of criteria that the mental health sciences would recognize? If so, what are those criteria? How do you differentiate a mentally disordered sex offender from a felony sex offender, sometimes called an opportunistic sex offender?

Thirdly, even if you can differentiate, in terms of some meaningful psychological and mental health characteristics,

should societal response be to treat or to punish? If you make the decision to treat, who should supervise the treatment -- generally speaking throughout the United States -- the Department of Health, which controls state mental hospitals, or the Department of Corrections? The decision one makes on that, or the Legislature makes on that, also determines what the criteria for release are going to be.

ASSEMBLYMAN MIKULAK: The Department of Human Services controls mental institutions.

DR. PALLONE: Pardon me?

ASSEMBLYMAN MIKULAK: The Department of Human Services controls mental institutions.

DR. PALLONE: In the State of New Jersey.

ASSEMBLYMAN MIKULAK: In the State of New Jersey.

DR. PALLONE: But, I'm very much aware of that, Assemblyman. In fact, the case is, that in the State of New Jersey, the issue did not arise until 1974 because the single agency handled both Corrections and Health and Human Services. It was shortly after that change that I was asked by Commissioner Klein to serve on the board.

A couple of other points I would make before addressing the issues that I was asked to address in conversations with Ms. Tasch of your staff:

First, I guess the major point is that, in my judgment, New Jersey probably has the worst of all possible worlds in that we have a specialized treatment facility which is controlled by the Department of Corrections, not by Health and Human Services, which is funded as if it were a correctional facility rather than a mental health facility.

Comparisons are constantly being made about the relative effectiveness of Avenel in the discharge of its legislative mission, not against what it costs per inmate day in a State psychiatric hospital, but what it costs per inmate day in a prison. Those I think are very, very different.

We're now down to, and I brought with me-- I was quite surprised that Mr. Freeman-Longo quoted a term of 1700 treatment programs. There are probably 1700 treatment providers that have registered with Safer Society. They include licensed social workers who have, on one occasion, been involved with a brother/sister, ages seven and six, whose mother found them playing doctor.

According to the Bureau of Justice statistics of the U.S. Department of Justice, "Source Book of Criminal Justice Statistics," there are now only 13 states left in which there is some form of sex offender treatment that is controlled by the Department of Corrections rather than by the health agency.

SENATOR BASSANO: Are you talking about the program, or the institution where these people are housed?

DR. PALLONE: Sometimes, Senator, the institution -- the facility -- is a general prison facility with a part of it designated for the housing of sex offenders.

SENATOR BASSANO: I can understand--

DR. PALLONE: And a program provided.

SENATOR BASSANO: I can understand a facility that is operated by the Department of Corrections with the program being administered by either Human Services or Health. That I can understand and I can appreciate. I think that the distinction has to be made as to what we're going to emphasize, whether it is going to be treatment or incarceration. Unfortunately, the public is going to demand both. So perhaps a dual type of system is what we would be looking at. Right now, we're not doing that. I think you're aware that Corrections runs everything.

DR. PALLONE: I am certainly aware of that.

I presume that you have already had the benefit of the American Bar Association's current thinking?

SENATOR BASSANO: We've not spoken to the Bar Association.

DR. PALLONE: Well, then let me quote -- and this is a good indication that the issues are not local issues at all. The American Bar Association's Task Force on Criminal Justice/Mental Health Standards issued a report in 1990. It contains this provision, and it is quite clear and unequivocal. The rationale underlying this provision has to do with some of the issues I've attempted to suggest.

"Statutes which provide for special sentencing and treatment of sexual psychopaths should be repealed. Standard 781" -- that is internal to the documents of the American Bar Association -- "now embodies a formal expression of Association policy condemning all special sentencing statutes governing such categories of convicted offenders as sexual psychopaths. Offenders who repeatedly commit new offenses can be dealt with under habitual offender laws or other statutes providing for sentencing enhancement."

So it is a very clear statement, because-- There was a time when there were 39 states in this country that had programs similar to the program at Avenel. We're now down to 13, including New Jersey. We, perhaps, have come late to the discussion of some of these issues.

I was asked by Ms. Tasch to address two matters, specifically. First: What works in the treatment of sex offenders? Secondly: What are the standards that are generally recognized on the part of providers of treatment services?

May I distribute a handout? (affirmative response)

What I have done on this sheet is, very briefly, to summarize several hundreds of studies having to do with treatment effectiveness.

The first question is: What represents a baseline? In my judgment, the appropriate baseline is that adopted by Professor George Dix, University of Texas Law School, in his evaluation of the California program.

The California program was very similar to the New Jersey program, a two-tiered program. One for felony sex offenders who were simply incarcerated for punishment; the second, the criminal sexual psychopaths who were incarcerated for treatment.

Dix said, quite cogently, "Let's find out whether treatment works better than simply locking them up and keeping them in the slammer." Dix's study demonstrates that seven years after release from punitive incarceration, felony sex offenders recidivated at the rate of 7 percent, which is a fairly small proportion.

Then we have studies, really since the 1930s to the 1990s, which can be categorized under the general rubrics I've used here, ranging from surgical castration -- we still get about 4 percent recidivism, by the way -- all the way down to outpatient, individual therapy. Surgical castration was mandatory in Northern Europe until really the beginning of World War II and voluntary thereafter in some nations.

Rather than give you precise proportions, I've simply indicated baseline plus, better than the baseline, baseline minus, baseline double minus. I also have attempted to suggest in the final column what the impediments are to the application of each of those techniques within a facility that is operated by a State authority, whether it is Corrections or Health, and which is, therefore, bound in a way that private practitioners are not, by the way, to the constraints -- Professor Brooks knows a lot more about this than I do -- about how you go about treating prisoners that have been laid down judicially and legislatively.

Do we know what works? You bet we know what works. Can we do it? We can't do it. Aversive behavior therapy, according to one of the decisions -- Wyatt, I think, maybe Donaldson. The Supreme Court says of aversive behavior therapy that you've got to tell the person it's going to hurt; that he

or she has the right to withdraw consent at any time and for any reason.

It would be stupid to gear up a program to operate an aversive behavior therapy regimen, when, in fact, upon the first delivery of electroshock, the patient can say, "Hey, wait a while. I've changed my mind."

So, the fact is, ladies and gentlemen -- and it's not just in the State of New Jersey, but in programs operated by the Department of Corrections all over the country -- the kinds of treatment modalities that are operationally available, that can really be carried out in the real world, tend to be rather tame. They are not the ones that produce dependably the most positive results.

Let me turn quickly to the next question and that is the relevant standards of care matter, with particular attention to providers. There are a number of organizations, you probably know about them, that are concerned with the treatment of sex offenders.

One is the Association for the Treatment of Sex Offenders, or ATSO. Another is the Association for the Behavioral Treatment of Sex Offenders; it comes out to be a different acronym. Then there is an umbrella organization called The International Conference on the Treatment of Sex Offenders. That is an organization associated with the School of Medicine at the University of Minnesota.

At the last such international conference, representatives of the various organizations involved met, produced a set of standards, proposed standards, earlier on, which I originally published in the "Journal of Offender Rehabilitation" inviting comments from around the world, so on and so forth. They've gotten that kind of feedback, and so what we now have is a final version of those standards.

We're in press. What I'm going to give you is a set of uncorrected page proofs from the "Journal of Offender

Rehabilitation." Probably, we'll not be on the newsstands until the end of May or thereabouts.

Specifically, within the topic of standards of provider qualification that was specifically raised, I would point out that the current requirement is for a master's degree in a relevant mental health discipline with licensure. Now, there is a question about licensure that has a whole lot to do with this stream of licensure legislation.

In New Jersey, we now license psychiatrists through the Board of Medical Examiners, psychologists, through the Board of Psychological Examiners, but also social workers, marriage and family counselors, and the most recent addition is mental health counselors that also is at a masters level of certification. I believe it is the case that the implementing regulations are yet to be written on that.

Senator?

SENATOR BASSANO: I guess the first question that I would throw out at you would be: Do you believe we would be better off administering the treatment of these prisoners through another agency rather than the Department of Corrections?

DR. PALLONE: Senator, for most of these 19 years I have been Chairman of SCRB. For most of that period, I was part of the senior administration of Rutgers University. I did not like it when members of the Rutgers' board attempted to micromanage the institution. I would not like it, if I were Bill Plantier, to have the Chairman of the SCRB try to micromanage. So, could I answer the question by saying, "Not Avenel, but an institution in some state?"

SENATOR BASSANO: Sure.

DR. PALLONE: In the general?

SENATOR BASSANO: In the general.

DR. PALLONE: Yes, my response there is, I think that in a general case, the appropriate place for the administrative

housing for the supervision and all the rest that goes with that--

SENATOR BASSANO: I'm not talking about the housing end of it. Maybe we're using housing in a different definition? I'm talking about the actual administration of the program itself, as to who will be in charge of that program.

DR. PALLONE: I think that, optimally, it should be whatever the authority is that operates the public psychiatric hospitals.

SENATOR BASSANO: Human Services in this State, Health in other states.

DR. PALLONE: But, understand that a whole lot of baggage comes with that. On the positive side, it is doubtless the case that one gets better medicine right off the bat. It is now 1995, psychotherapy, verbal treatment-- I mean, I belong to a dying profession. In 15 years from now, there won't be a clinical psychologist left except a couple of old fossils like me.

Mental health treatment is now largely neurobiologically based.

SENATOR BASSANO: You would classify this as mental health treatment, without a doubt?

DR. PALLONE: Without a doubt. If the law says to confine that son of a gun for treatment--

SENATOR BASSANO: There is a dilemma, because this is a penal institution. Now, you have to make a decision as to who has supervision and who makes the final call.

DR. PALLONE: Yes. That is exactly what I am suggesting, Senator. That is part of the baggage, and part of the thinking that went behind-- I've read just the conclusionary paragraph from the American Bar Association document, a whole lot of discussion of just exactly this character before they reach that conclusion.

It is also the case, however, that if you are providing treatment, it becomes very difficult to talk about punitive treatment. Now, so we've got a guy, not a nice, friendly brother/sister game of playing doctor, not even a nice, friendly piece of incestuous behavior between mother's 21-year-old husband and a 15-year-old stepdaughter; we're talking about violent, predatory rapists. That involves running a kind of high-security, very high-security mental hospital institution. But, if you confine the person for treatment, then you kind of have to be willing to let him go when the people who are treating him say, "He's cured."

If you're not willing to do that, then I think-- What I recommended in my book, "Rehabilitating Criminal Sexual Psychopaths," is a volunteer program that is not terribly different from what Mr. Freeman-Longo outlined before lunch.

There is no question that a crime has been committed. Society has the right to punish you. I would not reserve a portion of the final few years of sentence, but instead say, "After you have served a certain proportion of sentence, you may volunteer, if the treatment staff finds you acceptable" -- this is what has happened in Canada, by the way -- "because you can demonstrate that you have those characteristics" -- whether they are measured by Bob Hare's scale, or by some other set of instruments -- "that you are amenable to treatment, and they accept you. Then, at the conclusion of that treatment, you may become eligible for parole."

SENATOR BASSANO: That is the precise type of network that we are looking at. I'm sure that is what is going to be recommended to this Task Force once we start to put together our report.

But that doesn't answer the problem as to who has final jurisdiction over the institution; that is, administering treatment, because these people are still incarcerated. That is the dilemma that I have.

DR. PALLONE: Senator, my understanding of the folkloric history of how Avenel got this way is that at a certain point, in roughly '74 or '76, after the Supreme Court had rendered certain decisions having to do with the rights of mental patients, and after the Legislature of the State of New Jersey had adopted a Bill of Rights for mental patients, the folk in Commissioner Klein's office said, "Wow, we can't possibly deal with these folks that way" -- you know, weekend furloughs, so on and so forth.

SENATOR BASSANO: So we ship them over.

DR. PALLONE: There are some issues that are going to have to be addressed. If this was a question that came as a kind of intellectual question over the transom, I know that the person I would go to for a response would be Professor Brooks.

ASSEMBLYMAN MIKULAK: How do they currently deal with the Vroom building for the criminally insane? That is under Human Services? The prisons ship their disturbed prisoners down there?

DR. PALLONE: Yes, but those are acute cases, short-term stays. Basically, what you're doing is you've got somebody who is radically assaultive, radically suicidal, he goes down and gets stabilized on medication. So he may be there for two weeks, four weeks at maximum, and comes back with a set of prescriptions. Now, we even have a Supreme Court decision on involuntary medication when it is psychiatrically necessary.

So those are not long-term stays for anything more than psychopharmacological stabilization.

SENATOR BASSANO: Are there questions?

MR. THOMAS: No, I do not, at the moment.

MR. MULLER: I'll reserve my comments to the end.

SENATOR BASSANO: Okay. I appreciate your comments. They definitely were helpful, and we thank you.

ASSEMBLYMAN MIKULAK: It does present a very thorny problem. It's a Gordian knot, so to speak.

SENATOR BASSANO: Okay. Anne, would you read off the next list of witnesses?

MS. STEFANE: Dr. Greenwald and Dr. Witt, New Jersey Psychiatric Association and New Jersey Psychological Association.

SENATOR BASSANO: Good afternoon.

D A N I E L M. G R E E N W A L D, M.D.: Good afternoon.

SENATOR BASSANO: Thank you for being with us.

DR. GREENWALD: Thank you for giving us this opportunity to testify.

I am Dr. Daniel Greenwald. I am President of the New Jersey Psychiatric Association. With me is Dr. Philip Witt, immediate past President of the New Jersey Psychological Association.

I am here, first, to present a joint position paper of the New Jersey Psychiatric Association and the New Jersey Psychological Association on the treatment of sex offenders. I've distributed copies. I won't just read the whole thing, but I'll basically go over it.

We do believe that there should be a treatment facility for sex offenders in New Jersey. There are a few reasons we can say. One, of course, is the benefit to the offender. It gives the maximum opportunity for the offenders to get their lives back together and to lead normal lives.

The other benefit, of course, is to society as a whole. Unless the person has done something that warrants a lifetime sentence, he is going to have to be released sometime, and I would think in the meantime, society would want to do everything it can to decrease the chances that he is going to commit another offense.

There is ample literature indicating that sex offender treatment programs can work. I don't know if we can use the word cure. It is very difficult to say about any particular individual or any group of individuals, to make an assessment

that they are cured. But, certainly, there is ample evidence that the rates of recidivism can be brought down with proper treatment.

We have several recommendations to make, more specifically, about the nature of the treatment facility and what it should offer. We do feel that the treatment program has to be run by a clinical director at the doctorate level, who reports directly to the director of the whole facility. We think it would be a disadvantage to have a layering of bureaucracy between the director of the facility and the director of the treatment program several notches down.

We believe that most of the treatment program and the personnel involved in treatment should be responsible to the clinical director. Going along with what we just said, of course, we know that many of the people in this program will need to be in a maximum security institution. We think, obviously, the housing is going to have to be run by Corrections.

We also think there should be incentives for the prisoners, the offenders, to participate in treatment. To the maximum degree possible, or the maximum degree feasible, we believe offenders should either not get paroled if they do not participate in the treatment program, or that their refusal to participate, if it is a voluntary treatment program, should have a great deal of effect on whether they get parole or not.

We also believe that it is going to be terrifically advantageous if we can perform lifelong follow-up, or at least follow-up after discharge for as long as possible. We think we would advise to have some kind of hook onto the offender so that he would have to do this.

In other words, this could be some kind of system of lifetime parole, or parole for an indefinite period, when the only condition of the parole might be simply that he report for follow-up -- for the follow-up for treatment and for assessment,

so we can gather data about how well the program is working and how well it's running.

Now, from time to time, I suppose, or in certain circumstances, this may conflict with somebody's legal rights. That is out of my area. I can't really say what the legal rights are, but within the framework of the person's legal rights, we believe these things should be done.

It follows, then, that I think there should be facilities somewhere in the State or scattered throughout the State, for lifelong evaluation, assessment, and follow-up, so we do keep tabs on how well the program is running.

Another reason for wanting to keep a program in place right now is that many of the new medications that have come out -- you've all heard of Prozac, and it has many relatives. Some of these are thought to be of potential value in the treatment of sex offenders. I think it would be a shame if we kind of let this opportunity for research and for new treatment go by the board without doing something about it or without making some kind of investigation as to how well it could work.

Now, as we discussed these issues, certain questions were brought back to us from the Legislature about more specific issues. One of them was whether the facility should be run by the Department of Corrections or by the Department of Human Services.

We agree pretty much with what was just said. The housing would probably have to be done by Corrections, but the clinical part of the program would preferably be run by Human Services under a clinical director of a doctorate level, a Ph.D. or an M.D. I don't think Human Services in this State is set up to run correction facilities. Largely, this is an administrative issue, I think, to be decided by administration and not necessarily so much based on expert testimony.

The other question is: Where to carry out the treatment? The advantage of having one centralized facility is

that there are many different types of sex offenders requiring different types of programs, and if they were scattered about, then any one given facility might not have enough offenders of any one category to have a good program there. It would also be harder to coordinate the program, to run it, and to supervise it properly.

The obvious advantage to having them scattered is that the sex offender treatment facility, if it is going to be a totally beneficial, well-run, or optimal prison, would also have to duplicate the vocational rehabilitation and so on that is found in prisons. So we think there are advantages and disadvantages both ways, and the final decision can be an administrative one.

ASSEMBLYMAN MIKULAK: Excuse me for a second?

DR. GREENWALD: Yes.

ASSEMBLYMAN MIKULAK: They are scattered now. About 60 percent of the sex offenders in the system are scattered, and the other 40 percent who are repetitive are in Avenel.

DR. GREENWALD: I see.

ASSEMBLYMAN MIKULAK: So it is not so clear-cut.

DR. GREENWALD: No, I don't think it's completely clear-cut, and I don't think there is any one answer that I would want to advocate as being the only way to do it. These kinds of things can be done both ways.

The other question we were also asked was whether to mix different type offenders in one facility. For the most part, we think this is possible. There is going to be segregation for the treatment program; that is, in the sense they will be attending different parts of the program or different types of therapy sessions. There is no specific reason why they can't be housed together, that we know of, apart from the reasons we already have, sometimes, of not putting prisoners in the same place.

SENATOR BASSANO: When you're giving treatment, is it better to have 15 or 20 people who all committed the same type of crime receiving the same type of treatment, or are you better off with a mix during group therapy?

P H I L I P H. W I T T, Ph.D.: If I can answer that, Senator?

SENATOR BASSANO: Yes.

DR. WITT: In addition to being the immediate past President of New Jersey Psychological, I actually worked at Avenel, having served as Director of Psychology and Director of Research there. For the last eight years I've been in private practice, but I have had a fair amount of experience evaluating and treating sex offenders.

The answer to your question is, "Yes." Actually, it can be either way, and ideally should be both. My experience at Avenel is that some of the particular treatment components were homogeneous, a group of all child molesters, a group of all incest offenders. Some of the other treatment components were heterogeneous, where they mixed them together. That, in my experience, has been the ideal; where you do both.

If I may make a few additional comments?

SENATOR BASSANO: Yes.

DR. WITT: The question, first of all, is where to house? There apparently has been a lot of discussion about that. I really don't know of any evidence that indicates that housing it in Corrections or in mental health works better one way or the other.

Clearly, I think we would all agree that with a population that has broken the law in serious ways we would want security. It has to be a secure facility. Most of the secure facilities are in the Department of Corrections. There is, of course, the forensic psychiatric hospital that really is the exception that seems to prove the rule, that all of the other secure facilities tend to be in the Department of Corrections.

So I would assume, that the odds are it would be within the Department of Corrections.

SENATOR BASSANO: The only question that keeps coming up is the services that are being rendered are not a correction type of service. It is a mental health type of service, which then puts you over into Human Services, the same as you would be dealing with someone who has a mental problem, placing them in a facility such as Greystone. Greystone happens to be run by Human Services, but could just as easily be run by the Department of Corrections. It's a tough call.

DR. WITT: That's true. It's a hybrid. I mean there are elements of both.

SENATOR BASSANO: That is a good description. It's a hybrid.

DR. WITT: It is a hybrid. You know, in all the time I worked at Avenel, we were kind of balancing between those two poles. We had violent incidents there. There were escapes. There were assaults. I think all of us who worked there wanted it to be a secure facility. I certainly felt safer knowing that it was a secure facility. On the other hand, we all felt, at times, inconvenienced by the security. Inconvenience, I think, is acceptable. I would prefer a secure facility.

SENATOR BASSANO: I think so would the public.

DR. WITT: I think so.

As far as who would provide the treatment, I think as long as there is a clinical director with some experience and some credentials in the field, as long as the staff is well-trained in this particular specialty -- and it is a specialty -- it really doesn't matter whether the treatment program is administered through Corrections or through Human Services.

SENATOR BASSANO: I know when we started the program, into the late '70s early '80s, the program was a model program and that was a model under Corrections.

DR. WITT: That's correct.

SENATOR BASSANO: I think as we started to increase the caseloads at the facility and started to really overcrowd the facility, we started to run into some problems.

DR. WITT: I couldn't agree more. In fact, if I could share briefly some personal experience?

SENATOR BASSANO: Yes.

DR. WITT: I was appointed Director of Research back in the mid '80s and relieved of my caseload to develop some automated physiological laboratories. We set up a plethysmograph laboratory there. We wanted to do some research.

That was just the point at which the institution started to get crowded. So very shortly after I was relieved of my caseload, I was gradually given the caseload back until I had as large a caseload as I had previously. No fault of the institution. I mean, we didn't want the other therapists carrying enormous caseloads, so I picked up my share. But it really prevented us from doing the kind of research that we wanted to do.

Dr. Greenwald has pointed out that we, in our joint letter, are encouraging support for research. I think it's essential. I mean, I have to admit that all of the State institutions are funded primarily as treatment facilities and research was always viewed as secondary. But I think as we've seen here, unless you have real statistics to support the effectiveness of the program, it's difficult to convince the public that it is working or not.

SENATOR BASSANO: We've made note of the need for additional research. One of the things that we may be asking for is a line item in the budget, perhaps to Rutgers University, with some dollars to start some research separate and apart from the Department of Corrections.

Because one of the problems that you run across when you're running on a tight budget is you try to look where you

can cut. If we put research off to tomorrow, we have the extra dollars today to do things and that becomes fine. Where, if it's given to Rutgers as a budget item, the Department can't tamper with it, there is no temptation, and, perhaps, we can get some meaningful research done at the State University.

DR. WITT: Certainly, they have the skills to do it there. We did a preliminary pilot study back in the early '80s where we evaluated the people we released from Avenel compared to the people in the regular prison system who were also sex offenders, although not repetitive compulsive. Our statistics, admittedly, just a small pilot study, were very different from those that Dr. Pallone presented.

He cited a base rate of 7 percent recidivism. We found that, when we corrected for time on the street and things like that, that those in the regular prison system recidivated at a rate of 33 percent or 34 percent. These were nonrepetitive compulsive. Those at Avenel recidivated at 17 percent or 18 percent. We were actually quite pleased with those results. We felt that we were taking a more difficult population, repetitive compulsive, and reducing their recidivism to roughly half of that of an untreated, easier population.

SENATOR BASSANO: We believe, if we started to be more selective in people who were going to Avenel and receiving treatment, that the 17 percent or 18 percent could be reduced drastically.

DR. WITT: I would agree.

SENATOR BASSANO: By basically saying that there are some people who should never go back into society, and if you continue to incarcerate them through civil commitment, the chances of another incident happening out there that is major or anything of that type, the figure would drop down and, hopefully, drop down drastically.

DR. WITT: I agree. Avenel, in my understanding, has something of a problem with treatment refusals. Obviously,

there is no sense having a treatment center that just houses people. They should be moved elsewhere and people motivated to work at Avenel. Perhaps those people who are treatment refusals, or are those who we can determine through whatever measures still present a danger to the community upon parole, should be committed in one way or another.

SENATOR BASSANO: I think we want to look at those people based upon their case where it looks like there is a good chance that we're going to succeed if we treat them. That is the individual that we want to get to. Those people who, obviously, no matter what you do you're not going to get to them, maybe, they shouldn't even be there but continue to be incarcerated.

DR. WITT: I agree.

ASSEMBLYMAN MIKULAK: Also, you touched on another problem when you said, in the general population, the sex offender who is nonrepetitive comes out, he recidivates, then he becomes repetitive. I had asked the Department of Corrections, through OLS, a few months ago, to provide me with details of therapy in the different institutions. They still have not done that.

DR. WITT: There is very little.

ASSEMBLYMAN MIKULAK: It's not standardized either, I would imagine. From what I gather, it's spotty.

DR. WITT: Assemblyman, my understanding-- Now, I can't speak as a spokesman for the Department of Corrections, but my understanding is that there is very little organized treatment for sex offenders in the other prisons. There may be one or two groups.

By the way, let me clarify something Dr. Greenwald said. We certainly agree that sex offenders within themselves don't need to be segregated, rapists from child molesters from incest offenders, but I would put forth the position that they do need to be segregated from other prisoners. It is very

difficult in a general prison population to run a treatment program for sex offenders, because no people want to admit in a general prison population that they are a sex offender, for obvious reasons.

SENATOR BASSANO: I want to get into a very touchy subject, if I may. One of the things that was discussed at one of the early meetings we had was the problem of a person who has committed a crime, still has the urges to commit additional crimes, and wants help. That person, if they were to contact a psychiatrist or a psychologist under the law today -- if they go for help -- the physician would have to report that person in the event there was a minor child involved. Which then prevents that individual from seeking help, simply because of the fact that he knows or she knows that they are going to be caught and it is going to become public record.

Should we be looking at some type of umbrella, whereby, an individual of that type can seek help without having the reporting being mandatory by the treating physician?

DR. WITT: It is a dilemma, there is no doubt about it. In my private practice I still treat, because of my background from Avenel, many sex offenders. But 99.9 percent of them are referred by attorneys, the courts, or the prosecutor after they've been charged.

SENATOR BASSANO: After they've been caught?

DR. WITT: After they have been caught.

SENATOR BASSANO: But what about a person who hasn't been caught and wants help?

DR. WITT: I understand. That is a real dilemma. I don't have an answer to it. Every state in the union has a child abuse reporting law.

SENATOR BASSANO: Do we think about allowing just the psychiatrist not to be part of that law if a person comes for help, or do we just leave the law as it is? It reminds me almost of the law that we had for years -- the Lindbergh law, if

you remember -- on kidnapping. If you kidnapped a child, mandatory death penalty. Well, every child that was kidnapped was killed because people knew they were going to die.

DR. WITT: No witnesses.

SENATOR BASSANO: So, as a result, we finally got smart and changed the law. Maybe this dilemma is somewhat similar to that.

DR. WITT: You know, I'm not an expert on drafting law, as did Dr. Pallone--

SENATOR BASSANO: Don't think we are up here.

DR. WITT: I would defer to Professor Brooks on that. But perhaps the law can be narrowed in the circumstances under which an individual reports, be narrowed so there are certain exceptions. Off the top of my head, I couldn't draft it for you, but perhaps something like that could be done.

DR. GREENWALD: I agree that it is a dilemma. I think the only kind of way to draft the exception would be if the sole source of knowledge is from the person himself seeking treatment. Then the psychiatrist or mental health treater might either, on his own discretion, not report it as long as the person stays in treatment, or report it to an agency which would then, perhaps, not incarcerate the person as long as he is not a danger and stays in treatment.

I mean, that's one way to try to construct it. Again, it would be hard to construct the details, but perhaps it could be done under that kind of outline.

ASSEMBLYMAN MIKULAK: I don't think we can afford to weaken our child abuse reporting laws.

SENATOR BASSANO: It's a tough issue. I guess we'll talk about it, but whether we'll get into it or not in the report, I'm not sure. But it is a dilemma that we are going to have to deal with.

DR. WITT: It is a very tough issue.

DR. GREENWALD: Well, this isn't only childhood abuse reporting laws. A person who says he has a tendency to be a voyeur and asks for treatment, even if the only potential victims are adults--

SENATOR BASSANO: Of course, the one concern we have is that we don't want that to be a shield so the person doesn't have to go to prison. But it is a difficult issue, and I think we'll kick it around a little bit when we start to put together this report. Whether we'll come up with an answer or not, I'm not certain.

DR. GREENWALD: Well, you see, the way I think to prevent it from becoming a shield is that if the police can find out that he did it and the district attorney can find out, they can still deal with him.

SENATOR BASSANO: I think your approach is a middle-of-the-ground approach and maybe something we ought to look at.

DR. GREENWALD: That's why I was saying some kind of separate board that the mental health treater could refer to, so that that wouldn't become part of the police record or the district attorney's record.

SENATOR BASSANO: I see Anne taking notes, so perhaps your suggestion will be brought up when we meet next time.

Are there any other questions or comments from our people?

DR. BROOKS: I would like to ask just one factual question.

SENATOR BASSANO: Sure, Dr. Brooks.

DR. BROOKS: You mentioned research at Avenel with a plethysmograph. Did Avenel have a plethysmograph?

DR. WITT: I set up a plethysmograph lab there. Again, I probably operated it for perhaps all of six months when I had to resume my caseload, and it gathered dust since then. It's probably still there.

DR. BROOKS: So it may still be there somewhere in a closet?

DR. WITT: I am sure it is still there some place, in some closet.

DR. GREENWALD: The only other thing I have is, I do have a paper which is an outline of treatment outcome with sex offenders. It was published in 1991 by a Canadian psychologist. If the Task Force wants a copy, I have one for you.

DR. WITT: This is the most current review of sex offender treatment that I have been able to find, 1991.

DR. BROOKS: Who is that by?

DR. WITT: William Marshall.

DR. BROOKS: Oh, Marshall, yes.

DR. WITT: Apparently, you have it already.

SENATOR BASSANO: Any additional comments or questions? (no response)

We do thank you. Thank you for being here.

DR. WITT: Thank you.

DR. GREENWALD: Thank you.

MR. MULLER: Professor Brooks, much of this Marshall report was in one of our previous packages.

DR. BROOKS: Yes.

MR. MULLER: I notice how you always smile when the academians walk in.

DR. BROOKS: Really? (laughter)

Well, maybe it's because I know them.

SENATOR BASSANO: Elizabeth Anastasio.

This is our last witness. After she is finished, that will conclude our meeting for today.

Good afternoon.

E L I Z A B E T H A N A S T A S I O, ESQ: Good afternoon, gentlemen and ladies.

As you know, my name is Elizabeth Anastasio. Just so you know a little bit about me: I'm a lifelong resident, born,

bred, and raised in New Jersey. I attended the New Jersey public schools system. I'm educated through Seton Hall University and Seton Hall School of Law.

My connection to ADTC is as a regular visitor over the last two years and as a self-appointed, nonlegal advocate to some of the inmates there. I visit, I accept collect phone calls, and obtain information they may request that they can't otherwise get from inside ADTC.

I've been visiting at ADTC for a little over two years now. In those two years, I've had numerous conversations with inmates regarding the benefits they have derived from treatment at ADTC. I'd like to draw the distinction here that these are inmates who are actively participating in the treatment program.

Some of the inhouse problems that have come up on a regular basis have been a regular topic of our conversations: problems in ADTC, upsets that they encounter, and benefits in treatment, what works for them in the treatment program.

On an aside, I've had the pleasure of meeting Dr. Jeffrey Allen, who used to be the Director of Treatment. The inmates who have been under his care speak very highly of him and value the treatment they receive with him as their therapist.

I strongly feel that a patient under the care of a therapist who has trust in their caregiver, in their therapist, and who has high regard for them will benefit more than from a therapist who is not responsive to them or in whom they don't have confidence or trust.

A couple of the other counselors that you spoke with at a prior meeting, Susan Beshak, who is, I believe, a drug abuse counselor, and Craig Conway, are also highly regarded by the inmates they treat. These two counselors, I know, have spoken out in a prior meeting contrary to statements made by William Plantier. Just my personal impression is that their testimony is probably more reliable.

A couple of the programs that I've had conversations about as far as being of benefit to the inmates; one in particular has been the art therapy program. One of the inmates in particular who has come into the art therapy program has personally related to me the benefits he has gotten from this program. It has created a new outlet for him that he did not have previous to his admission into ADTC.

Prior to his being confined in ADTC, he told me that his only diversion was work related. Because he was a craftsperson, everything he did as a diversion was related to his work and there was nothing else. Now, he has discovered and is developing a talent in creative pursuits, and that has helped build his self-esteem, as well as other inmates who are in the art therapy program. They have also discovered hidden talent that they didn't know they possessed. That is something that when they are able to be released, they can potentially hook into as a resource not only of recreation, but possibly as income.

There are some concerns that have come up on repeated basis on my visits to ADTC. One of the primary concerns is potential for therapy program cutbacks, a potential for less groups, or fewer group meetings.

MR. MULLER: You can't get any less than one.

MS. ANASTASIO: I know. A lot of times it is less than one--

MR. MULLER: That's what it is now.

MS. ANASTASIO: --because therapists a lot of times don't show for their meetings. If there is a snow storm, a holiday, or a State meeting is called, the session isn't held for sometimes two or three weeks, or more, consecutively.

Therapy refusals is a big issue with the inmates themselves. The inmates participating in treatment resent what they call "TRs" -- therapy refusals -- remaining at ADTC, contrary to part of the stated purpose of ADTC which is

treatment. The inmates who are in treatment would like to see the TRs removed to other facilities to make room for those who are on the waiting list and who are willing to undergo a treatment program.

Medical care and emergency response at ADTC are not something I would want to submit my worst enemy to on occasion. One particular physician -- I don't know his name, and wouldn't reveal it if I did -- is not viewed as a competent physician. One particular inmate who I speak with on a regular basis has, on occasion when he had been seriously ill, had to insist on seeing another physician in order to receive appropriate medication.

Also, the guards apparently are not trained in CPR or the Heimlich maneuver. One of the inmates with whom I speak regularly said that on a meal break one particular evening, he witnessed an inmate friend of his choking. Before he could get up, another inmate grabbed him and did the Heimlich maneuver because the guard who was stationed in that area didn't know how to perform it.

It is my feeling that all the guards, since emergencies do arise and because of the security requirements at ADTC, be able to perform and be certified on CPR and the Heimlich maneuver on an annual basis.

The phone system that has recently been installed and in place; I know it's systemwide. Receiving calls on a regular basis, their calls are limited to 15 minutes by an automated system. This cuts down on their access not only to family and other outside people that they wish to have--

SENATOR BASSANO: May I interrupt you?

MS. ANASTASIO: Yes, sir.

SENATOR BASSANO: What you're doing is giving us a list of complaints of the inmates of the institution. We want to talk about, if we can, therapy and what we can do to improve the therapy.

What we're hearing from you is what we heard from some of the inmates. It was an opportunity for them to vent some of the problems they're having. If I were to have a hearing on Rahway State Prison, I would get the same thing.

MS. ANASTASIO: But it is my feeling that in order for the therapy as a whole to be effective that the environment be as protective of their well-being as possible, and that basic human concerns also be included.

SENATOR BASSANO: I think that the administration tries to do what they can with regard to basic human concerns, but based on the overpopulation, it is a problem, and understand that it is still a prison.

MS. ANASTASIO: I understand that.

SENATOR BASSANO: Try to understand that it is still a penal institution. It is certainly not a facility where you are getting just treatment. What you're telling me-- I've gotten volumes, not a handful, volumes of letters from prisoners complaining about the same thing. Assemblyman Mikulak is no different.

ASSEMBLYMAN MIKULAK: We've gotten letters.

SENATOR BASSANO: This Task Force is not doing penal reform. It is doing the treatment of Avenel and how we can improve that particular problem.

MS. ANASTASIO: Part of my purpose in coming here today was to communicate to you that from my conversations and dealings with the inmates -- the few inmates that I deal with, because I only deal with two to four -- are receiving value, very good value from the treatment they are receiving. They could receive better. There could be much more value received by the inmates who receive treatment at Avenel, but due to budgetary concerns, funding concerns I'm sure, there is less than there used to be.

SENATOR BASSANO: That is, I think, one of our biggest problems; there is so little.

MS. ANASTASIO: From sitting in on a good portion of the testimony today, I can appreciate the huge undertaking this Task Force has in trying to make its recommendations. For what it was worth, I felt, pardon the expression, compelled to come down here and throw my two cents in.

SENATOR BASSANO: I would be delighted to pass on to the Commissioner some of the concerns that you just expressed, but I don't think that those concerns are going to be addressed by this Task Force.

Maybe I was a little harsh with you, and if I was I apologize, but I don't think that is what we're charged with doing. What I'm hearing from you is repetitious, because it's not the first time I've heard it. But, again, we're not going to move in that area. It's like people saying, "What about the juvenile offender?" That is not what we are charged with doing, even though we know it's a major problem.

MS. ANASTASIO: I appreciate that. I do want to stress to the Task Force that I know Rob Freeman-Longo was discussing earlier the concept of intensive therapy. I had a brief conversation with Professor Brooks over the concept of intensive therapy, and the more modalities of treatment that can be delivered to someone in a facility like ADTC, or at ADTC, the more they are going to get out of their treatment program.

One or one and a half hours a week of group therapy isn't going to do it.

SENATOR BASSANO: I think we all agree with that.

MS. ANASTASIO: The more you can enable the facility to have, or recommend that somehow it be funded to have, the better treatment they're going to provide. The ultimate outcome is, when these men are eligible to get out, what is going to become of them? Are they going to recommit, or are they going to be contributing members of the community again? The value of and the comprehensiveness of the treatment is going to be key to that.

If you don't treat them adequately and comprehensively, then the risk of the higher risk inmates recommitting is going to increase. I think the lower risk inmates-- Those especially who are incarcerated because of incest convictions are low risk and are less likely to recommit, because the fact of the matter is they probably have court orders that they can't have contact with that family anyway. So, taking them out of that environment postrelease, where is the risk that they are going to recommit?

I don't see a general trend that someone who commits incest then goes out and becomes a rapist or a predatory child molester. It doesn't happen. I have to say that there are a couple of inmates who I visit at ADTC, I would feel safe in a closed room with them before I would feel safe in a closed room with some of the guards there.

SENATOR BASSANO: I'm not too sure you're that incorrect in your statement. (laughter)

MS. ANASTASIO: Just for a final note, I know, Senator Bassano, you in particular are interested in some type of postrelease program, especially a halfway house, which the inmates are very concerned for. They would like to see that type of program where, if they have no place to go, if there is no family to go to, or no friend who can take them in when they are released, that they have at least six months or a year in some place they can go to and have aftercare: a place to call a roof over their head and not be concerned about a vigilante attack, their own personal safety, or the safety of their families if they should be visiting.

SENATOR BASSANO: Well, I look at it a little different than you do. I think it is a gradual reintroduction back into society, but a very small percentage would probably need that help. Those people who don't have families are the people that we would be looking at. But that is something that we would ask a permanent commission, that I hope this body will

agree should be established, to take a real hard look at and maybe report back to the Legislature as to whether they think an establishment of that type is warranted.

MS. ANASTASIO: Even those who don't necessarily need a halfway house facility-- But based on the fact that these men will have been incarcerated anywhere from -- on max out -- four years to thirty years or more, no matter what time frame, they've been out of society for some period of time and are going to need some type of reintroduction. Whether that is counseling on how to get job placement or aftercare with a therapist, it should still be available.

SENATOR BASSANO: In most cases I think there are families that are there to help them. But you and I know that there is a small percentage who don't have any relatives in the State or don't have any family at all, and that is where a half-way house would come into play.

MS. ANASTASIO: I think there is an inherent conflict societally right now with the high emotions that are running in the public over Megan's Law. I fear a reluctance of families of some of these men, or a large number of these men, to be willing to take them back. If they have to face--

SENATOR BASSANO: I don't think that is much different than if you have a family member who is in a mental institution, anybody who is institutionalized, or a family member who went to general prison.

MS. ANASTASIO: But someone who has been in a mental institution doesn't potentially face having their name published to the entire community or given to the police or whomever. Someone who has been released from Rahway, with or without parole, doesn't have their name released to the entire community, and their families and friends can usually live with some protection of their privacy. Whereas, when you have sexual offenders who are potentially having that portion of their privacy removed, it makes it more difficult to reintegrate.

SENATOR BASSANO: I understand where you are coming from. I understand the desires of the community to ask for a safe society and wanting to know if they live in a safe environment. It is a very difficult issue. Again, we're not going to deal with that issue. The Legislature addressed the issue with Megan's Law. It is being challenged in court. If we have to readdress it at the legislative level, we will, but that is not what we are going to be talking about here.

MS. ANASTASIO: Thank you.

SENATOR BASSANO: You're welcome.

Are there any questions? (no response)

Thank you very much.

MS. ANASTASIO: Thank you.

SENATOR BASSANO: Before we break--

Bill, I know you have the toughest schedule because you're not in the area a lot. Steve and I were talking about the next time we would get together and try to meet behind closed doors to hash out a report. When is good for you and when is bad for you?

MR. THOMAS: Any time after the 1st, I'll be home.

SENATOR BASSANO: After the 1st, okay. Because we want to try to get that meeting as quickly as possible. Our problem may be getting a few people together.

MR. THOMAS: I can't afford many more trips from Hilton Head.

SENATOR BASSANO: I know, I know. I appreciate you coming back, really. We'll all come down to Hilton Head, how's that? (laughter)

ASSEMBLYMAN MIKULAK: If we go too far into April, the Legislature is out of session. It will be hard to get--

MR. THOMAS: That's all right. I've got a way to go, too, if you want to go to Hilton Head. It's very reasonable. You catch a commuter plane out of Hilton Head Island. You go to

Charlotte, you get another one to Philadelphia, and from Philadelphia you go to Atlantic City.

SENATOR BASSANO: We figure you're going to be home by next Tuesday.

MR. THOMAS: Well, I got home in five hours that way, and I'm going back tomorrow morning at 7:00 the same way.

SENATOR BASSANO: We're going to take a look and try to get our group together as quickly as possible depending on everyone's schedule. So, what I would suggest to those of us who are here, start making note of the areas that you want to cover. Then let's hash it out and we'll see if we can come up with a report.

Yes, Professor.

DR. BROOKS: Senator, do you think it would be helpful if someone, Anne, for example, or the two Cochairmen, would prepare some kind of tentative agenda?

SENATOR BASSANO: We're doing that now.

DR. BROOKS: You are doing that?

SENATOR BASSANO: Yes. We both asked Anne--

DR. BROOKS: So at least we have a structure to start with.

SENATOR BASSANO: But there are going to be specific things that each of you are going to feel should be part of that report.

DR. BROOKS: Oh, sure.

SENATOR BASSANO: I remember Gregg bringing up something at the last meeting regarding the keeping of records.

MR. MULLER: I've got it all written out here. So at the next meeting I'll summarize it.

SENATOR BASSANO: Whether that will be in here or not, he should bring it up, that sort of thing.

DR. BROOKS: In other words, the agenda that you're preparing would not be the final one, but at least it would be the beginning of a structure?

SENATOR BASSANO: It's a rough agenda. Okay? Hopefully, we'll come up with something that is workable.

DR. BROOKS: By the way, the reason I raised the question about the plethysmograph is that I was told by one of the staff that they did not have one.

SENATOR BASSANO: It's in the report that they don't have one. Anne pointed that out to me.

DR. BROOKS: Yes, and I specifically raised that question because I think that was a misrepresentation.

SENATOR BASSANO: Absolutely.

(MEETING CONCLUDED)

APPENDIX

JOURNAL OF OFFENDER REHABILITATION: IN PRESS
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Standards of Care for the Treatment of Adult Sex Offenders

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ABSTRACT A proposed version of these standards were first produced and published through input from a variety of professionals and input from professional meetings (Coleman and Dwyer, 1990). Since that time, the current set of authors (and Kurt Freund, M.D., William Marshall, Ph.D. and William Murphy, Ph.D.) have reviewed those proposed standards and have made the following changes. The Standards of Care herein were unanimously endorsed by voice vote by the participants of the 3rd International Congress on the Treatment of Sex Offenders which was held in Minneapolis, Minnesota on September 20-22, 1994. The authors invite feedback from readers. Further revisions are anticipated and will be reviewed by the existing committee members and at future International Congresses on the Treatment of Sex Offenders. Please address your comments or write for reprints of this article to Eli Coleman, Ph.D., Director and Associate Professor, Program in Human Sexuality, 1300 S. 2nd Street, Suite 180, Minneapolis, Minnesota USA 55454.

From puberty through adulthood, males more than females experience erotic fantasies and dreams of a paraphilic type. A paraphilia is a

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condition of compulsive response to, or dependence upon, an unusual and unacceptable stimulus in the imagery of fantasy, for optimal initiation and fantasy during solo masturbation or intercourse with a partner.

There are well over 40 types of paraphilias which have been identified and defined (Money, 1986). Only eight of them are listed in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1987), where the remainder are subsumed under, "not otherwise specified." Given the socio-cultural-religious-political climate, some paraphilias are legally considered to be sex crimes which are punishable by law. In legal codes, crimes against nature and affronts to socially acceptable sexual behavior are criminalized and are regarded as sex offenses. These crimes have included statutory rape, violent rape, child molesting, exhibitionism, voyeurism and incest. What is considered a sexual crime and the standards of punishment are state, time, and culture dependent. Over time, there have been many revisions of the criminal sexual codes (Pallone, 1990).

For the most part, today sex offenders may be fined, ordered to psychological or medical treatment, and/or imprisoned. For first-time offenders, and for lesser offenses, there is a greater likelihood of probation, subject to some professional sex offender treatment.

Although treatment is costly and unaffordable by some, not to treat can be more costly emotionally and psychologically for the offender, for the victims and future victims, and for society.

Today there is more scientific evidence and consensus among professionals that paraphilias are psychosexual disorders. By contrast, the predominant view of the lay public around the world is that sex crimes can be eradicated with punishment and/or death. This predominant view is not supported by scientific evidence, and the scientific community needs to continue to promote awareness that sex crimes can also be the manifestations of biomedical/psychiatric/psychological illnesses for which people must be treated, rather than simply punished.

In recent decades, the demand for sex offender treatment has increased, as have the number and variety of possible biomedical/psychiatric/psychological treatments. The rationale upon which such treatments have been offered has become more and more complex. Various "appropriate care" philosophies have been suggested by many professionals who have identified themselves as experts on the topic of sex offenders.

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In an effort to establish minimal acceptable guidelines for the treatment of sex offenders, the authors present the following Standards of Care as guidelines which might be helpful to enhance the ethical and professional treatment of sex offenders throughout the world.

STATEMENT OF PURPOSE

Although each profession has its own standards of care, the following are minimal recommendations of Standards of Care. It is recommended that professionals involved in the treatment of sex offenders use the following minimal criteria for the evaluation of their work. It is recommended that the reasons for exceptions to these standards, in the management of any individual case, be very carefully documented.

DEFINITIONS

Standards of Care

Standards of Care are exactly what is implied: standards for caring for patients. In this case: care and treatment of sex offenders.

Paraphilia

Paraphilia is an erotosexual condition occurring in men and women who are responsive to, or dependent upon, an unusual or socially unacceptable stimulus in the imagery or fantasy for optimal initiation and maintenance or erotic-sexual arousal and the facilitation or attainment of orgasm.

Sex Offense

If paraphilia is enacted in actual behavior rather than in erotic fantasy or dream, it may qualify as a criminal sex offense. There is great discrepancy throughout the world as to what constitutes a sex offense (Pallone, 1990).

Sex Offender

An individual who commits a sexual crime as legally defined in his or her own culture or legal jurisdiction.

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Psychological Treatment

Psychological treatment refers to the array of therapies which have been designed to treat sex offenders. Different treatments are based on different psychological and psychiatric theories regarding the origin of the paraphilic sex offending, for example, psychoanalytic, cognitive, behavioral, social learning, and family systems theories. Psychological or psychiatric care can be provided in individual, couple, family or group settings. The purpose of treatment is an attempt to prevent further offending behavior and further victimization of others.

Biomedical Treatment

Biomedical treatment refers to the use of pharmacological treatment or neurosurgery for the purpose of altering sexual fantasies, impulses, and behavior. Pharmacologic therapy has included (but is not limited to) the use of antiandrogens, antidepressants, and antianxiety, antiepileptic, antipsychotic, or other medications.

Surgical treatment might involve brain surgery to correct temporal lobe seizures. With the advent of effective chemotherapies which alter the erotosexual response, the necessity of psychosurgery in the absence of epileptic foci has been rendered inappropriate.

PROFESSIONAL COMPETENCE

Possession of an academic degree in a behavioral science, medicine, or for the provision of psychosocial clinical services does not necessarily attest to the possession of sufficient competence to conduct assessment or treatment of paraphilic or sex offending problems. Persons assessing and/or treating sex offenders should have clinical training and experience in the diagnosis and treatment of a range of psychiatric and psychological conditions and also specialized training and experience in the assessment and treatment of paraphilic and sex offender problems. This would generally be reflected by appropriate licensure as a psychiatrist, psychologist, or clinical therapist and by documentation of training and experience in the diagnosis and treatment of a broad range of sexual conditions, including paraphilic disorders and sex offenses. Treatment providers must be competent in making a differential diagnosis. The following minimal standards for a professional should be adhered to:

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- ☐ 1. A minimum of a master's degree or its equivalent or medical degree in a clinical field granted by an institution of education accredited by a national/regional accrediting board.
- ☐ 2. Demonstrated competence in therapy as indicated by a license (or its equivalent from a certifying body) to practice medicine, psychology, clinical social work, professional counseling, or marriage and family counseling.
- ☐ 3. Demonstrated specialized competence in counseling and diagnosis of sexual disorders and sex offending behaviors as documentable by training or supervised clinical experience, along with continuing education.

ANTECEDENTS TO SEX OFFENDER TREATMENT

- ☐ 1. Prospective patients should receive an extensive evaluation of their sex offending behavior which would include appropriateness for treatment, amenability for treatment, psychological/psychiatric diagnoses, evaluation for safety and protection for the community.
- ☐ 2. A thorough physical examination is recommended especially when physical problems are suspected that might require specific treatment, i.e., heart problems, high blood pressure, liver damage, brain lesions, and epilepsy.
- ☐ 3. Prospective patients should receive a psychological and/or psychiatric examination which would rule out other psychological/psychiatric disorders. If any other psychological/psychiatric disorders are found, treatment of that require separate treatment prior to treatment for paraphilic or sex offending behavior.
- ☐ 4. If medication is deemed necessary or requested by the patient, the patient must be given information regarding the benefits and potential side effects or disadvantages of biomedical treatment.

THE PRINCIPLES OF STANDARDS OF CARE

- ☐ Principle 1: While treatment effectiveness of adult sex offenders has not been clearly demonstrated, there are indications that some kinds of treatment may be effective in managing and reducing recidivism with some types of sex offenders.
- ☐ Principle 2: Sex offender treatment is viewed by offenders as an elective process (the choice is theirs), since individuals may not view their sex offending behavior as psychologically or medically pathological.
- ☐ Principle 3: The evaluation of treatment of sex offenders requires specialized skills not usually associated with the professional training of clinical therapists or medical professionals.

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- ☐ Principle 4: Sex offender treatment is performed for the purpose of improving quality of life and is considered a humane treatment for people who have committed a sex offense and to prevent the patient from engaging in further sex offending behavior.
- ☐ Principle 5: The patient with a documented biomedical abnormality is first treated by procedures commonly accepted as appropriate for any such medical conditions before beginning, or in conjunction with, psychotherapy.
- ☐ Principle 6: The patient having a psychiatric diagnosis (i.e., schizophrenia) is first treated by procedures commonly accepted as appropriate for the psychiatric diagnoses, or, if appropriate, for both simultaneously.
- ☐ Principle 7: Sex offender treatment may involve a variety of therapeutic approaches. It is important for professionals to keep abreast of this growing and developing field and provide the most efficacious treatments which have been demonstrated through outcome studies. Some of the most effective approaches available today involve cognitive and behavioral therapies which include increase in victim empathy, control over offending urges and relapse prevention.
- ☐ Principle 8: A treatment plan may involve the use of pharmacotherapy which typically relieves some sexual arousal and fantasy. Impulse control is thereby increased and individuals feel less driven by their sexual compulsion or their paraphilic fantasy imagery. Principle 9: The current treatment of sex offenders often causes special legal problems for the professionals offering such care and treatment. Therefore, the professional should work with the criminal justice system in a professional and cooperative manner.
- ☐ Principle 10: Sex offenders often have a need for a follow- up treatment/visits, and this should be encouraged or possibly required.
- ☐ Principle 11: It is unethical to charge patients for services which are essentially for research and which do not directly benefit the patient.
- ☐ Principle 12: In order to effectively persuade the professionals in the legal community as well as society in general about the efficacy of sex offender treatment, professionals should cooperate with and carry out scientifically sound treatment outcome research.
- ☐ Principle 13: Sex offenders often must face legal proceedings, and professionals treating these individuals must be prepared to appear in court if necessary.
- ☐ Principle 14: Sex offenders are given the same rights to medical and psychological privacies as any other patient group, with the exception of where the law requires otherwise, i.e., reporting laws, subpoenaing of records.

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AGGRESSIVE AND STANDARD MODALITIES IN TREATING CRIMINAL SEXUAL PSYCHOPATHS ARRAYED BY RELATIVE EFFECTIVENESS

MODALITY	*FINANCIAL COSTS*	*EFFECTIVENESS IN REDUCING **SEX-OFFENSE** RECIDIVISM*	*IMPEDIMENTS, ISSUES*
➲ BIOIMPEDANCE			
Surgical Castration	Moderate, one-time	*Baseline ++*	Court decisions based on 8th, 14th Amendments; permanent incapacitation
Neuroosurgery [Psychosurgery]	Moderate, one-time	*Baseline +*	Court decisions based on 8th, 14th Amendments; permanent incapacitation; neurologic side effects not known
Chemical Castration	Moderate, continuing	*Baseline +/-*	Libertarian arguments, Constitutionally-based; long-term neurohormonal effects not known
➲ AVERSIVE BEHAVIOR THERAPY			
Treatment by Revulsion	High, one-time + "booster" sessions	*Baseline ++*	Libertarian view likens to "brainwashing"; Supreme Court constraints [Wyatt, Donaldson, Pugh]
➲ PUNITIVE INCARCERATION WITHOUT TREATMENT			
INCAPACITATION	Approximates $25-$30K year	BASELINE	According to Dix, 7% seven years post-release
➲ INPATIENT, DURING CONFINEMENT			
Group Therapy	Moderate, putatively one-time, but greater than standard incarceration	*Baseline --*	Effectiveness not better than punitive incarceration; cost may be 25-35% greater
Individual Therapy	Moderate, putatively one-time, but greater than standard incarceration	*Baseline --*	Effectiveness not better than punitive incarceration; cost may be 50% greater
➲ OUTPATIENT, WHILE ON PROBATION			
Group Therapy	Relatively low, putatively one-time, borne by offender	*Baseline =/-*	Effectiveness equal to, lower than punitive incarceration; off-loads costs from public to private resources, likely discriminatory by SES
Individual Therapy	Low, putatively one-time, borne by offender	*Baseline =/-*	Effectiveness equal to, lower than punitive incarceration; off-loads costs from public to private resources, likely discriminatory by SES

[Adapted from NJ Pallone, *Rehabilitating Criminal Sexual Psychopaths: Legislative Mandates, Clinical Quandaries*. Transaction Publishers, 1990. pp. 79-102.]

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NEW JERSEY
PSYCHIATRIC
ASSOCIATION
A District Branch of the American Psychiatric Association

POSITION STATEMENT

TREATMENT FACILITY FOR SEX OFFENDERS

As representatives of the New Jersey Psychiatric Association and the New Jersey Psychological Association, we would like to make this joint statement regarding the general issue of treatment of sex offenders and the particular issue of the future of the Adult Diagnostic and Treatment Center at Avenel.

The professional literature demonstrates that treatment for sex offenders, if properly implemented, can be effective. A recent thorough review article (Marshall 1991), cites considerable evidence that relapse rates for sex offenders can be lowered by effective and comprehensive treatment. The efficacy rates of treatment for sex offenders in some instances compares with the efficacy of the treatment for other mental disorders.

We, therefore, strongly support the proposal that New Jersey should maintain a sophisticated and well-supported sex offender treatment program.

We have several recommendations regarding the structure and operation of such a program. We strongly feel that no treatment program can be effective unless most or all of these practices are in place.

It goes without saying that the facility must be adequately funded and adequately staffed by competent and credentialed professional personnel. There should be a clinical director at the doctorate level reporting directly to the superintendent of the facility. There should be no layering of administration between the chief superintendent of the facility and the highest level clinical administrator.

In order to insure that all residents participate maximally in the treatment program, there should be strong incentives for offenders to participate actively in treatment. These incentives could include parole or

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time off for good behavior. We strongly discourage early release for offenders who do not actively participate in treatment.

In order to perform adequate evaluations of the results of various kinds of treatment, the facility should have the capability for long-term follow-up. To insure that offenders stay in long-term treatment and in follow-up for outcome evaluation, consideration should be given to such measures as lifelong parole or lifelong probation even after the offender has served a maximum sentence.

Discharges, whether final discharges, parole, etc., should take into account clinical considerations as well as the actual time served in relation to the sentence. We realize that those who have served their time have certain legal rights to freedom; nevertheless we recommend that when decisions are made regarding release from institutionalizations, clinical considerations should be taken into account along with the offender's legal rights.

It follows from the above arguments that there must be facilities and opportunities for ongoing treatment after release, whether at the treatment facility itself or in the community. If any law mandates the hospitalization or other institutionalization of certain people as compulsive, repetitive sex offenders, then procedures should be in place so that these offenders are hospitalized or institutionalized in settings which are capable of controlling them, evaluating them, and treating them. In particular it is extremely problematic for compulsive, repetitive sex offenders to be hospitalized in the psychiatric units of general community hospitals. In such facilities these patients would frighten other patients and would have no opportunity to obtain treatment particular to their needs.

Lastly, it needs to be recognized that there are several different types of offenders. Sexual offenders vary by age and sex of the victim, the use of force, and frequency of repetition. There are several modalities of treatment, including hormonal, behavioral, cognitive and conditioning types of treatment.

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In addition, several recent medications, in particular those medications which alter the brain metabolism of serotonin, have shown promise as adjunctive treatment to the rehabilitation of sex offenders. Opportunities to do research in this area should not be missed. Treatment programs and evaluation programs must take into account the various types of offender, the various types of treatment, and the relationships between them.

Lastly we wish to deal with a few questions of a more detailed nature. We have made mention of the need for a strong clinical director. We recognize, of course, that most of the individuals at a sex offenders treatment facility will have been convicted of a crime. Thus there will always be a need for adequate security.

Nevertheless it is imperative that there be a clinical director strong enough to insure a professional atmosphere in dealing with the inmate/patient population. When non-professionally trained people come into close contact with a vulnerable population there is always the danger of inappropriate behavior. Either the facility should be under the direction of the Department of Human Services; or should report directly to the Governor's office; or should have a clinical director with sufficient authority to insure that such behaviors do not occur.

Another issue is the question of where to carry out treatment. Obviously treatment could conceivably be rendered in one central facility, as in Avenel; or treatment programs could be offered at each of several prisons. The main disadvantage to one central treatment facility is that other types of facilities, such as library, exercise room, vocational training programs, etc. would have to be duplicated or the inmates will be without the benefits of these facilities. The main disadvantage of separate treatment teams in each prison is that the program may lack some cohesion and there may be less emphasis on maintaining a strong treatment program. We believe that this is largely an administrative decision.

We also believe that different types of populations can mix in one facility. Some of the treatment programs would be separate for different classes of offenders such as exhibitionists or rapists; other parts of the program

would be the same. Different types of offenders can be segregated for different aspects of the program when need be. There is no real need to have separate treatment locations and facilities for different classes of offenders. Indeed one of the advantages of having all sex offenders treated in one centralized location is that if the treatment teams are separate, each facility may not have enough of each given class of offenders to constitute a good treatment group in that specific facility.

Gentlemen,

My name is Elizabeth Anastasio. I'm a lifelong resident & native of NJ. I'm educated in the NJ Public School System & attended Seton Hall University and Seton Hall School of Law. I work for a small mutual insurance company in NYC.

My connection to ADTC is as a regular vistor at ADTC and self-appointed non-legal advocate. I visit, accept phone calls and obtain information requested but not readily available to inmates. I've been visiting at ADTC for a little over 2 years.

In those 2 years, I've had numerous conversations regarding benefits derived from treatment at ADTC, in-house problems especially medical care, and conversations on various concerns and upsets encountered.

Comments on Treatment:

I've had the pleasure of meeting Dr. Jeffrey Allen briefly. The inmates to whom I have spoken speak highly of him and his abilities. He's perceived by the inmates he treats as an excellent therapist, straight talker and doesn't accept B.S.

Other counselors, e.g. Susan Baschack and Craig Conway are regarded highly also. Trust in, and high regard of a therapist is crucial to progress in therapy. These two counselors spoke out at the last meeting of this task force with opinions contrary to Wm. Plaintier's. My impression is that their testimony is probably the more reliable.

The Art Therapy Program is highly valued by the inmates who choose it as part of their program. It provides a creative outlet to often unknown talent. One inmate with whom I visit never had any other diversion except work prior to entry at ADTC. He has told me of other inmates never exposed to art as young men who have demonstrated talent. Access to creativity and development of interest and a talent for art increases their self esteem. Increased self-esteem is crucial to progress in any therapy setting.

Of additional value is the education program offered at ADTC, which includes GED and college programs. Education-increasing a person's base of knowledge-increases the ability to meet challenge in a positive manner.

In my conversations and visits, some concerns of inmates have repeatedly come up:

These are:

1) Therapy program cut backs - less groups available.
   - fewer group meetings.
   - cancelled meetings - group or individual, due to weather, other state meetings, etc.; unresponsive therapists.

2) Therapy - Refusals

   - Inmates participating in treatment programs resent that T-R's remain in ADTC contrary to the stated purpose of ADTC; part of which is treatment.
   - Inmates in treatment would like to see the T'R's removed to other facilities to make room for those on the waiting list <u>who</u> are not at least <u>willing</u> to undergo a treatment program.

3) <u>Medical Care</u>/<u>Emergency Responses</u>

   Physicians - one in particular, is not viewed as competent. He treated one inmate for a cold when he had bronchitis and required strong antibiotics. The inmate had to insist on being seen by the other physician who would at least <u>listen</u> to him and his medical history.

Until late last year, there was no emergency call system in the exercise yard. While having a heart attack, an inmate waited 45 minutes before other inmates could get the attention of a tower guard. (They have installed a "panic button" in the yard since).

The guards don't know how to perform CPR or heimlich manuever. An inmate performed it on another choking inmate during a meal because the guard didn't know how to do it.

All Guards should be required to certify in CPR and heimlich manuever annually.

4). Phone system to call out creates inaccessibility to lawyers and family as calls are limited to 15 minutes, and can only be placed through an automated, collect calling system.

My personal concern also goes to the perception of sex offenders as uncurable. If you refer to DSM 3R - pedophilia, etc. are <u>compulsive disorders</u>. Compulsive disorders are treatable to the extent a person remains committed to a daily lifestyle which includes self examination, meetings, support systems, and treatment.

This goes to the complete lack of post release support facilities and programs.

There is No Post release programs or pre-release preparation program of significance. Inmates have (1) no safe interim place to go if can't go home or be taken in by a friend or relative.

(2) No instruction on how to apply for public programs; housing; assistance.
(3) How to handle job applications, etc.
(4) Additional post release support/treatment is needed.

I know Sen. Bassano is in favor of a half-way house program. There is a definite need for such a program or some alternative to provide post release treatment and aftercare.

My last request is that the legislators on the task force consider an alternative program for breaking the chain of sex offenses which often arise out of earlier abuse of the offender. My suggestion is legislation offering treatment without prosecution to anyone who turns himself/herself in for treatment and as long as that person ceases their behavior. This would offer someone in an abusing role the opportunity to stop and get help without risk of prosecution and avoid increasing the population of ADTC. I would stress that my suggestion would be applicable only to those who voluntarily seek treatment.

Just prior to the closing of the last two task force meetings I made a statement. A copy of both statements and references are available.

At this time, after additional thought and research, I would like to summarize the results of my findings and offer the following summary:

1. New Jersey is one of the few, if not the only state, offering a separate prison facility for the evaluation and treatment of sex offenders. Other states offer treatment in a regular prison facility.

2. The states of Virginia and California have recently completed lengthy studies regarding the treatment of sex offenders. They are discontinuing their special programs as of June 1995. The programs were found to be non-effective and costly.

3. Of all of the psychologists, specializing in this treatment, that I have contacted in various parts of the United States, not one suggests a cure for a pedophile and only a small percentage can be helped. Recent studies show that lifetime parole and constant monitoring is required. We cannot continue releasing "maxed-out" prisoners into our communities. A nationally known psychologist has stated to me that without follow-up New Jersey has wasted treatment, time and its money. We have also endangered our innocent children.

4. We have been unable to determine the effectiveness of New Jersey's program as proper records have not been kept and no evaluation report has been made over the last

five years.

Our administrators of the Avenel facility have not been prepared to help this task force in the evaluation or investigation of the effectiveness of this program. They have stated that they are not responsible for the attitude and type of prisoner because the prisoners are assigned to Avenel by the courts. Their treatment and therapy is limited by the insufficient funds provided by the legislators. They cannot evaluate the effectiveness of the program or keep proper records because of the limited funds provided by Trenton. They do not control the readiness or time of release or responsibility for release of prisoners as they are being "maxed-out" by law.

5. Our state undertook this program approximately twenty years ago. At the present time our annual cost is in excess of twenty-five million dollars to house approximately 725 sex offenders. Where we offer at most four hours of group therapy per week - 30% of the 700 do not accept or receive any treatment - another 30% go through the motions only, have little interest and receive little if any help. So at best we have provided a full facility to provide limited treatment to 300 participating sex offenders without any records or study as to its effectiveness.

It is felt that we now must direct our tax dollars to programs with better potential results.

In conclusion I believe that we must change our sentencing practices. Sex offenders should be sentenced to serve their time in regular state prison. Therapy should be treated as a privilege that must be requested and warranted, and then furnish better treatment in a regular prison facility.

We have asked our Avenel administrators if they would comfortable with treated offenders released in their neighborhoods and their answer was in the negative. How can we continue to maintain this facility and release so called treated sex offenders unmonitored?

We have given this program more than ample time and it has not proven to be successful.

It is time to close Avenel as a Diagnostic and Treatment Center and put it to other use within our correctional system where we would have a much better potential for more rewarding results.

It is the duty of this task force to bring about change and not support the "status quo".

W. H. Thomas

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